S. HRG. 98-1117

IMPLEMENTATION OF PEER REVIEW ORGANIZATION (PRO) PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

JULY 31, 1984

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

39-958 O WASHINGTON : 1984

CZ61-73

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IMPLEMENTATION OF THE PEER REVIEW ORGANIZATION [PRO] PROGRAM

TUESDAY, JULY 31, 1984

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 1:07 p.m., in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger and Mitchell.

[The press release announcing the hearing, opening statements of Senators Dole and Durenberger, and a background paper prepared by the Finance Committee's staff follow:]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON IMPLEMENTATION OF PEER REVIEW ORGANIZATION (PRO) PROGRAM

Senator Dave Durenberger (R., Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the Subcommittee will hold a hearing on the implementation of the Utilization and Quality Control Peer Review Organization (PRO) program.

The hearing will be held on Tuesday, July 31, 1984, beginning at 1:00 p.m. in Room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing, Senator Durenberger noted that "problems to date with implementation of the PRO program necessitated the Deficit Reduction Act provision which delayed the date by which PRO contracts must be entered into from October 1 to November 15 of this year. The purpose of this hearing is to review the status of the program implementation and PRO contract negotiations. There is particular interest in seeing that the Secretary is able to meet the new deadline. Additionally, the Subcommittee is interested in the contractual criteria against which PRO performance will be evaluated. These criteria should assure that quality health care services are provided under the medicare and medicaid programs in an efficient and economical manner, but they should also allow a degree of flexibility given varying community needs."

Senator Durenberger further noted that the Subcommittee expects to receive testimony from the Health Care Financing Administration, from current and prospective PRO's, and from the American Medical Peer Review Association. Other interested parties may present their views by submitting a written statement.

OPENING STATEMENT OF SENATOR BOB DOLE

The prospective payment system we adopted for medicare creates an environment where hospitals are encouraged to provide care in the most efficient manner possible. At the same time, however, we also want to ensure that quality is maintained. The PRO Program was created by the Congress for that purpose. Its implementation should safeguard against any decline in the quality of care available to this nation's disabled and elderly.

Whether the program will be implemented in a timely manner continues to be a concern but is secondary to the questions now being raised. Those include whether the criteria against which PRO performance will be judged are overly restrictive,

address identified problems, reflect local needs, or are otherwise appropriate measures of PRO effectiveness.

I am anxious to hear from the department and others because the contract requirements we impose on PRO's will establish the direction PRO's take in performing the peer review that I believe is essential to maintaining quality care.

Opening Statement of Senator Dave Durenberger

The purpose of the PRO Porgram is to determine whether the health care services provided under medicare are medically necessary, of sufficient quality, and provided in the most cost-effective setting. That basic purpose is really no different from what was expected under the previous utilization review program.

Unlike PSRO's however, the new PRO Program was intended to interject an element of accountability into the process. Accountability in terms of whether the new review organizations meet specific performance criteria. As conceived, PRO performance criteria would reflect typical patterns of an area or local practice, while at the same time take into account national norms. Specific crtieria to determine contractor performance was to be negotiated and included in the contract between the Secretary and the PRO. This was to provide the Secretary and the contractor with a basis upon which to judge PRO performance fairly. The process was also to allow the flexibility needed for the Secretary and the PRO to tailor each contract to local or regional quality and utilization problems. Our intention was not to have objectives established that were so restrictive or so unrealistic as to make achievement of these objectives impossible. This is particularly true with respect to those objectives that measure quality of care.

At our last hearing, concern was expressed that very little attention had been given to quality of care as a PRO objective. Quality is now a element of the contract criteria but it seems to be expressed almost exclusively in numerical terms. Given the problems that exist with quantifying and measuring quality, I wonder whether those criteria are realistic. Is it possible to pick up a medical record and determine, on that basis alone, that an individual patient received quality care or that a death was avoidable? Or will a PRO need to also talk to the patient's attending physician, his radiologist, his pathologist, or his nurse before it can even hope to make a reasonable, much less an absolute, determination? Shouldn't PRO's also be held accountable for performing those functions which foster quality care, since problem identification, education, and corrective action are the kinds of things which assure that the system as a whole ultimately provides quality care.

Recently we have heard that the contracting process may not provide the results we had envisioned. Questions have been raised as to whether the criteria reflect local problems, are realistic or even achievable. While we do expect that the PRO's be held accountable, the question becomes how best to design the requirements to be met by a PRO and how to measure a PRO's contribution to cost effective quality care. Concur with PPS is incentive to extra admission and early discharge; the Admission, procedure and quality objectives/read in contracts operates to reduction in admissions and procedures. The administration and others are here to tell us how they view that accountability and whether the criteria that form its basis are reasonable, responsive to local problems, and most importantly, achievable.

THE PEER REVIEW ORGANIZATION PROGRAM (PRO)

Background Paper

Prepared for the Use of the Members of
The Committee on Finance

July 1984

PEER REVIEW ORGANIZATIONS

The establishment of a Utilization and Quality Control Peer Review Organization program to replace the existing Professional Standards Review Organization (PSRO) program requires the Secretary of Health and Human Services to enter into performance based contracts with physician-sponsored or physician-access organizations known as Peer Review Organizations (PRO's). Under the original provisions of the law, timely implementation of the new program was important because under those provisions hospitals were required to have agreements with PRO's by October 1984 as a condition for receiving Medicare payments under the new prospective payment system.

On February 1, 1984 the Subcommittee on Health held a hearing to explore the reasons for apparent delays in implementation of the PRO program. In recent weeks, progress on implementation has been made and a number of contracts have been awarded. As of July 25, 1984, 19 contracts had been awarded, and 8 contracts were awaiting signature by the offeror; 3 other areas were in the midst of negotiations.

I. BRIEF OVERVIEW OF HISTORY OF LEGISLATION

A. The "Tax Equity and Fiscal Responsibility Act of 1982"

The Tax Equity and Fiscal Responsibility Act of 1982 (commonly referred to as TEFRA) requires the Secretary to enter into performance based contracts with peer review organizations. A PRO is defined as an entity which either is composed of a substantial number of licensed doctors of medicine and osteopathy practicing in the area or has available to it sufficient numbers of such physicians so that adequate review of medical services can be assured.

The legislation requires the Secretary to designate the geographic areas which are to be served by a PRO, with each State generally designated as a single area. The Secretary is required to enter into a contract with a peer review organization for each geographic area. PRO contracts are for an initial period of 2 years, renewable biannually.

The Secretary is required to include in the contract negotiated objectives against which the organization's performance will be judged. PRO's may review, subject to the provisions of the contracts, the professional activities of physicians, other practitioners, and institutional and noninstitutional providers in rendering services to Medicare beneficiaries. The review is to focus on the necessity and reasonableness of care, quality of care, and the appropriateness of the setting. The determinations of the peer review organizations would ordinarily be binding for purposes of

determining whether Medicare benefits should be paid. Provisions are made for sanctions against health care providers and practitioners rendering unnecessary or poor quality services. Sanctions would be subject to appeal.

B. The "Social Security Amendments of 1983" (P.L. 98-21)

The "Social Security Amendments of 1983" authorized the establishment of the Medicare prospective payment system. This legislation requires hospitals receiving payments under the new system to enter into an agreement with a PRO under which it will review the validity of diagnostic information provided by the hospitals; the completeness, adequacy, and quality of care provided; the appropriateness of admissions and discharges; and the appropriateness of care provided to patients designated by the hospitals as outliers. Hospitals are required to enter into such agreements by October 1, 1984 (subsequently changed to November 15, 1984) as a condition for receiving Medicare payments. Where a PRO contract between the Secretary and a PRO is terminated after October 1, 1984, hospitals would not be penalized for the six-month period during which the Secretary is required to enter into a new contract.

C. The Deficit Reduction Act of 1984 (P.L. 98-861)

The Deficit Reduction Act contained four provisions further modifying the new PRO program. The first provision would permit limited representation of providers on a PRO board. Specifically, up to 20% of the members of a PRO governing board could be affiliated with providers. The second provision would permit entities whose board members include a representative of a self-insured employer to qualify as a PRO; in addition, an organization which has no more than one member affiliated with a health maintenance organization would not be classified as a payer organization and would therefore be permitted to qualify as a PRO.

The third provision would fund PSRO's still in existence, until a contract is signed with a new PRO, out of the Medicare trust fund.

Finally, the Act delays from October 1, 1984 to November 15, 1984, the date by which hospitals are required to have an agreement with a PRO. Similarly, November 15, 1984, is the first date on which a payer organization could qualify as a PRO.

II. IMPLEMENTATION OF THE PRO PROGRAM

A. Area Designation/Eligible Organizations

The final notice and regulation establishing geographic areas and organizational qualifications for Peer Review Organizations, respectively, were published in the Federal Register on February 27, 1984.

Key Provisions:

1. Organization Area Designations

   (a.) The notice establishes geographic areas throughout the United States for contracts under the PRO program.

   (b.) All States, the District of Columbia, the Virgin Islands, and Puerto Rico are designated as a separate PRO area. Guam, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands are designated as a single PRO area.

   (c.) In order to address local medical needs, a statewide PRO may subcontract with substate organizations. It may also establish criteria and standards to be applied to specific locations or facilities in its area.

2. Eligible Organization

   (a.) In order to compete for a contract, an organization must be either a physician-sponsored organization or a physician-access organization and must demonstrate the ability to perform review.

   (b.) Physician-sponsored organizations must be composed of a "substantial" number of the combined population of licensed doctors of medicine and osteopathy practicing in the review area and be "representatives" of these physicians.

   (c.) A physician-access organization must have available to it a sufficient number of licensed practicing physicians in the area to perform review functions.

   (d.) Any organization accepted as a PRO must be able to perform review. As a general standard, it must have acceptable utilization and quality review plans and resources sufficient to carry out those plans.

(e.) The regulation prohibits a PRO from having a hospital administrator, officer, or trustee on its Board of Directors. However, effective October 1, 1984, this prohibition will not apply to Medicare fiscal intermediaries who would then be allowed to qualify as PRO's if HCFA determines that no other eligible organization is available to be the PRO in an area. (This provision will require modification as a result of the Deficit Reduction Act of 1984.)

(f.) The regulation prohibits contracting with a health care facility or an association of facilities which provides services in the area that the PRO would review. In addition, the regulation precludes contracting with an organization that is affiliated with, through management, ownership or control, a health care facility, or association of facilities in that area. (Modification necessary due to Deficit Reduction Act of 1984.)

B. PRO Contracting Process

As noted earlier, the law requires that the Secretary enter into contracts with private contractors for the review of the quality, necessity, reasonableness and appropriateness of health care services furnished under Medicare. These contracts, which are for an initial period of two years and renewable biennially, must specify objectives to be achieved over the contract period. An assessment of the organization's performance will be made in terms of their meeting those objectives.

On February 28, 1984, HCFA published a notice advising potential bidders of the availability of the Request for Proposal (RFP) which form the basis of the contracts for the new PRO's. The RFP contains the Scope of Work, the Technical Proposal instructions and the Business Proposal instructions.

The bidders were instructed that their proposals should be in two parts: a "Technical Proposal" and a "Business Proposal." Each of these is to be separate and complete so that an evaluation of one may be accomplished independently of and concurrently with evaluation of the other.

The Business Proposal would contain information on the cost and pricing data supplied by the bidder. Information on salaries, fringe benefits, data collection costs and arrangements with subcontractors would be included.

The Technical Proposal would include the following information: the eligibility of the organization to participate; an understanding of the background (law, regulations) which prompted the proposed contract in addition to an understanding of

the scope and purpose of peer review; a description of the proposed objectives to be achieved and the required review activities; a description of the offeror's experience in conducting peer review; a description of the educational background, professional experience, and qualifications of the personnel of the organization; and finally a description of the management plan to be put into place by the organization.

Also contained in the RFP is a section entitled "Description and Scope of Work." Contained therein are detailed requirements that the organization must address in its bid. The following is a summary of the criteria contained in the Scope of Work:

1. Admissions

These objectives establish the improvement that the organization proposes to achieve. One or more objectives are required in each of the following areas:

(a.) Reduce admissions for procedures that could be performed effectively and with adequate assurance of patient safety in an ambulatory surgical setting or on an outpatient basis;

(b.) reduce the number of inappropriate or unnecessary admissions or invasive procedures for specific diagnosis related groups (DRG's); and

(c.) reduce the number of inappropriate or unnecessary admissions or invasive procedures by specific practitioners or in specific hospitals.

In addition, the contractor shall perform all of the following review activities:

(a.) Review, prior to hospital admission, every elective case proposed for five procedure-related DRG's or DRG groups from among those designated by HCFA;

(b.) review admissions occurring within seven days of a discharge and deny all claims for inappropriate admissions;

(c.) review every permanent cardiac pacemaker implantation or reimplantation procedure and deny payment for those that are unnecessary;

(d.) for every pacemaker reimplantation, obtain warranty information necessary to identify pacemaker costs reimbursable to Medicare;

(e.) review transfers from a hospital subject to PPS to either another hospital or to a PPS-exempt psychiatric, rehabilitation, or alcohol detoxification unit or to a swing-bed within the same hospital; and deny all claims for inappropriate admissions resulting from those transfers;

(f.) perform admission pattern monitoring;

(g.) perform admission review according to specific instructions prepared by HCFA;

(h.) review Medicare admissions to and days of care in specialty hospitals and distinct part psychiatric, alcohol detoxification and rehabilitation units; and

(i.) perform review and monitoring of hospital denials in accordance with the specifications prepared by HCFA.

2. Quality Objectives

At least one quality objective is required in each of the following areas:

(a.) Reduce unnecessary hospital readmissions resulting from substandard care provided during the prior admission;

(b.) assure the provision of medical services which, when not performed, have "significant potential" for causing "serious patient complications;"

(c.) reduce avoidable deaths;

(d.) reduce unnecessary surgery or other invasive procedures; and

(e.) reduce avoidable postoperative or other complications.

3. DRG Validation

The contractor shall assure that Medicare payments under PPS are correct by identifying whether the diagnostic and procedural information reported by hospitals and which resulted in a DRG assignment matches the diagnostic and procedural information contained in patient records.

4. Outlier Review

The contractor shall review every case involving day and/or cost outliers for necessity and appropriateness of admission and subsequent care.

5. In addition to these criteria, the contractor must also comply with special review requirements.

a. Waiver of Liability--The contractor shall make determinations under the waiver of liability provisions contained in the law. If the services are found not to be appropriate or necessary, and if notification has been made to the hospital, payment shall not be made.

b. Subcontracting--Subcontracts with other organizations to perform those aspects of the Scope of Work that lend themselves to localized performance of review WITH THE FOLLOWING IMPORTANT EXCEPTION: the contractor may not subcontract review with an organization which is a hospital, or which is affiliated with a hospital, or with an association of such facilities in its area except for quality review. The contractor shall be responsible for the performance of all contractual obligations and shall not be relieved of any responsibility in the event of nonperformance by its subcontractors.

c. Admission Pattern Monitoring (APM)--The contractor shall participate in a HCFA admission pattern monitoring system to assure that the Medicare discharges are appropriate in those hospitals identified by HCFA as having significant increases in quarterly discharges. The contractor shall perform APM in accordance with the specifications.

d. Peer Review--Physicians must be used to review the care provided by their peers. Additionally, the contractor shall use board certified or board eligible physicians or dentists in the appropriate specialty to make reconsideration determinations for the contractor. Other health care practitioners can be consulted where appropriate.

e. Criteria--PRO's would be required to use explicit written criteria based on typical patterns of practice in the geographic area or where such norms would not be effective in achieving contract objectives, regional, or national norms.

f. Data--PRO's would be allowed leeway in choosing methods of obtaining data. PRO's would be required to negotiate a memorandum of understanding with the fiscal intermediary (FI). FI data would be available free of charge to the PRO. The PRO could negotiate with the FI to purchase additional

data elements not presently collected. Confidentiality of PRO-specific data would be protected.

g. External Relationships, i.e., Providers and Third-Party Payors

(1) The contractor shall assume review in hospitals, including denial determinations, in its area according to the timetable negotiated with HCFA and included in its contract and shall comply with all requirements concerning relationships with hospitals specified in regulation.

(2) Confidentiality and disclosure requirements must be maintained as provided for in the law.

h. Sanctions--The contractor shall be responsible for initiating sanction recommendations as appropriate.

i. Abuse Issues--The contractor shall make available to HCFA the medical expertise necessary to render medical necessity or quality of care decisions on cases referred by Medicare contractors, the DHHS' Office of the Inspector General, or HCFA, and shall provide written evaluations of all cases submitted within 45 days of the receipt of the case.

j. Reconsiderations--The contractor shall provide a reconsideration, as the result or its own medical necessity or appropriateness of care denial determination, upon the request of a beneficiary or legal representatives. practitioner, or provider.

C. Competitive Bidding

The document made available on February 28, 1984, to bidders also outlines the evaluation criteria for the technical proposals submitted in response to the RFP. Each request for proposal would be accompanied by PRO area-specific data broken down by DRG categories for 1978-1981. The bidder would be required to develop acceptable objectives in quality, admissions, DRG, and outlier monitoring tailored to the specific geographic area. Further, the methodology to be used for achieving the objectives must be specified.

A point system for evaluating the proposals was specified. A maximum of 1,100 points could be awarded by HCFA with an additional 100 points automatically awarded to physician organizations.

According to the document, the following are the major categories and the maximum available points which could be awarded:

1.	Understanding of Work	50 points
2.	Objectives and Review Activities	600 "
	a. Proposed Specific Objectives and Required Review Activities	
	1. Admission Objectives and Required Review Activities	(200) "
	2. Quality Objectives	(200) "
	b. Approach for Accomplishing Other Activities	(100) "
	c. Data Collection and Analysis	(100) "
3.	Experience	150 "
4.	Personnel	200 "
5.	Management Plan	100 "
	Total Possible Points	1,100 points
	Physician-sponsored organization	+100 points

In addition to those areas noted above, the business proposal would also be evaluated through the use of a point system. The business proposal of the lowest priced technically acceptable offer will be given the maximum number of points. The total possible number of points is 300.

Issues with Respect to PRO Implementation

1. Objectives

Since the release of the Request for Proposal (RFP) and the negotiations with contractors began, issues have been raised about the admission and quality objectives that have been incorporated into the contracts. The setting of quantified objectives relating to goals like "elimination of avoidable deaths" and "reductions in admissions", have resulted in objections from the hospital industry, physicians, and some peer review organizations.

The Department of Health and Human Services argues that the numerical goals are based on information obtained in each State and are therefore representative of the needs of those communities. Those raising objections argue that the numerical

standards are too rigid and are unrealistic and therefore unlikely to be met.

When the legislation creating these new peer review organizations was discussed, there was a great deal of debate as to how an arrangement for peer review might be designed so as to allow for differences between communities. As a result of this concern, emphasis was placed on contract negotiations targeted on documented problems in that specific community. Also of concern was the ability of the Government to judge the effectiveness of these new organizations. There had been a great deal of difficulty in evaluating the former Professional Standard Review Organizations (PSRO's) because of the lack of measurable criteria. The response to this problem was to require that the contracts with the new organizations "contain negotiated objectives against which the organization's performance will be judged, and negotiated specifications for use of regional norms, or modifications thereof, based on national norms for performing review functions under the contract." Failure to comply with the terms of the contract results in loss of funding for the PRO. At issue at this time is the basis for the objectives established by the Department of Health and Human Services, the appropriateness of the objectives chosen, and the lack of flexibility granted the PRO in altering these objectives.

2. Waiver of Liability

Under current law payment may be made to an institutional provider of services under medicare for certain uncovered or medically unnecessary services furnished to an individual, if the provider could not have known that payment would be disallowed for such items or services. Hospitals, skilled nursing facilities, and home health agencies participating in Medicare are presumed to have acted in good faith, and therefore receive payment for services later found to be uncovered or unnecessary, if their total denial rate on Medicare claims is less than certain prescribed levels.

The denial rate in use for establishing a favorable standing, and permitting the hospital to be paid for these services, was 2.5 percent prior to March 1984. This percentage was determined by dividing the number of admissions denied by the total number of admissions.

In March of this year the Department of Health and Human Services revised the existing instructions governing the waiver of liability procedures for claims from hospitals subject to the Prospective Payment System.

Under the changed procedures an intermediary (and eventually a PRO) will: (1) have to make an individual finding in each denied case as to whether it is clear that the hospital should

have known that the services it furnished were excluded from coverage and (2) discontinue collecting denial statistics in the matter now required and follow instead the following new instruction.

Beginning with the first calendar quarter in 1984 a PPS hospital's denial rate will be based on the number of Medicare admissions denied or excluded as compared to the number of Medicare admissions reviewed (not the total number of admissions.)

$$\text{Denial rate} = \frac{\text{\# of admissions denied}}{\text{\# of admissions reviewed}}$$

If the hospital fails to maintain a level of 2.5% it will not qualify for a favorable waiver of liability presumption for the following quarter.

The use of admissions reviewed instead of total admissions reduces substantially the sample size, as a result a greater number of institutions, many of whom have had favorable waiver of liability treatment in the past, have lost such status. Some have suggested that this may be particularly true for small rural institutions, who are at particular financial risk if denied payment.

Hospitals argue that given that they are in the midst of implementation of an entirely new payment system, some leeway, instead of additional restriction, should be afforded and that if a smaller sample is to be used, the threshold for loss of favorable standing should be raised.

III. ADDITIONAL CONSIDERATIONS RESULTING FROM PROSPECTIVE PAYMENT SYSTEM REGULATIONS

On January 3, 1984, the Department issued final regulations implementing the prospective payment system provision of the "Social Security Amendments of 1983." These regulations specified that hospitals are required to have an agreement with a PRO beginning October 1, 1984. This was later modified by the Deficit Reduction Act of 1984, moving the date to November 15, 1984. Under the agreement, the PRO is required to review on an ongoing basis: 1) the appropriateness of the hospital's admissions, admission patterns, discharges, lengths of stay, transfers, and services furnished in outlier cases; 2) the validity of the hospital's diagnostic and procedural information; and 3) the completeness, adequacy, and quality of the services furnished in the hospital.

The regulations require HCFA to monitor hospital discharge rates. If these rates increase significantly, a report will be sent to the medical review entity (generally a PRO) for analysis.

If the entity finds a pattern of unnecessary or inappropriate admissions, it must intensify medical review activities in that hospital.

The January regulations require attending physicians to attest to the principal diagnosis, secondary diagnosis, and procedures performed. Since that time, proposed regulations have been published for comment which alter the requirements for a physician attestation. The proposed change is a revision of the language and method of implementation of the attestation requirement. A signed certificate would still be required for each discharge, however the penalty statement would be provided to the physician for his acknowledgement on only an annual basis. The medical review entity is required to review, at least every three months, a random sampling of discharges to validate the the diagnosis related groups (DRG's) to which inpatient cases are assigned. If the information attested to by the physician is inconsistent with the hospital's DRG assignment, appropriate assignments (and payment recalculations) must be made.

The regulations specified that HCFA can deny payment when a medical review entity finds that a hospital has misrepresented admissions, discharge, or billing information or has taken an action that results in the unnecessary admission of an individual entitled to Part A benefits, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices. These decisions may be appealed. Sanction determinations with respect to patterns of inappropriate admissions and billing practices for the purpose of circumventing the DRG system are to be made by the Inspector General.

Issues with Respect to PPS Implementation

The most frequently discussed issue is the physician attestation requirement. The January regulations had required a physician to sign a statement located at the beginning of a patient's chart, certifying that the description of the principal and secondary diagnosis and the major procedures performed are accurate to the best of his/her knowledge. Immediately following this statement was a notice stating that anyone who misrepresents, falsifies, or conceals essential information would be subject to fine, imprisonment, or civil penalty.

The proposed regulations published July 3, 1984, would modify the previous policy by requiring the physician to sign a statement, certifying that the narrative description of the principal and secondary diagnosis and the major procedures performed are accurate and complete to the best of his/her knowledge. The statement will now be located on the discharge summary sheet in the patient's record. The penalty statement would no longer be contained in each patient's record but would

simply have to be acknowledged in writing each year and record kept of such written acknowledgement by the hospital.

Notwithstanding these changes, physicians continue to object to having to sign such statements. They argue that the statements call into question their integrity and asks them to attest to a certainty about a diagnosis which may not be possible. For example, a patient could be admitted and, based on the best possible evidence available at that time, be treated for a particular diagnosis. Subsequent to discharge, new information could come to light necessitating a change in the treatment plan and diagnosis. Physicians question whether such a situation could lead to penalties for misrepresentation or falsification of claims.

PRO CONTRACTS STATUS REPORT AS OF July 25, 1984

NEGOTIATION PROCEEDINGS IN PROGRESS

Arizona - A	
Minnesota	
North Carolina	$7,760,806

CONTRACTS SENT TO OFFEROR FOR SIGNATURE

Colorado	$3,140,000	(MA support)
Indiana	$7,449,120	
Louisiana	$5,200,000	
Missouri	$9,000,000	(MA support)
Nebraska	$3,094,569	(MA support)
*New Mexico	$1,437,832	(MA support)
North Dakota	$1,462,455	(MA support)
Wisconsin	$7,150,000	(MA support)

CONTRACTS SIGNED	Amount	Date Signed	Effective Date	
Alabama	$6,350,000	7/10/84	7/1/84	(MA support)*
Arkansas	$4,376,814	6/25/84	7/1/84	(MA support)
Delaware	$ 694,242	7/6/84	7/1/84	
Florida	$14,340,000	7/13/84	8/1/84	
Georgia	$7,400,000	7/25/84	8/1/84	(MA support)
Iowa	$5,425,000	7/19/84	7/1/84	(MA support)
Kansas	$4,279,054	6/29/84	7/1/84	(MA support)
Kentucky	$6,500,000	6/22/84	7/1/84	
Mississippi	$3,630,504	6/28/84	7/1/84	(MA support)
Montana	$1,195,600	7/17/84	7/1/84	(MA support)
Nevada	$1,240,182	7/11/84	7/1/84	(MA support)
New Hampshire	$1,255,000	7/12/84	7/1/84	(MA support)
Oregon	$3,461,055	7/23/84	8/1/84	(MA support)
Rhode Island	$1,299,846	7/20/84	8/1/84	
South Carolina	$3,684,448	6/21/84	7/1/84	(MA support)
Tennessee	$7,481,233	6/22/84	7/1/84	(MA support)
Utah	$1,403,808	6/26/84	7/1/84	
West Virginia	$3,084,000	6/27/84	7/1/84	(MA support)
Wyoming	$ 524,078	7/17/84	7/1/84	(MA support)

*(MA support)=medical association support

Source: DHHA

Senator DURENBERGER. The hearing will come to order.

The purpose of today's hearing is to review the PRO, or Peer Review Organization Program. Let me start off with a little bit of a definition. Let me also say that the Administrator of the Health Care Financing Administration, whom I will introduce briefly, has agreed to stay for the presentations of the other people because, in the hour or 2 hours—whatever it will take today—I would like for all of us to come to some kind of general, or as close as we can, to a meeting of the minds on what we are doing. So, to that end, rather than having everybody operate this hearing as a printed-statement hearing that we summarize in 3 minutes, I have requested that everybody say whatever is on their minds and that the administrative agency, who has the disadvantage of going first—doesn't necessarily know everything that is on the minds of the other people—will stay and listen to what is on their minds, and then at the end, we will give them an opportunity to react once more. The purpose of the PRO Program is to determine whether the health care services provided under medicare are medically necessary, are of sufficient quality as measured by appropriate professional standards, and are provided in the most cost-effective setting. That basic purpose is really no different from what was expected under previous utilization review programs. Unlike the older programs, the PSRO's, the new PRO Program was intended to interject an element of accountability into the process. Accountability in terms of whether these new review organizations meet specific performance criteria. As conceived, PRO performance criteria would reflect typical patterns of an area or a local practice while, at the same time, taking into account national norms.

Specific criteria to determine contractor performance was to be negotiated and included in the contract between the Secretary of HHS and the PRO. This was to provide the Secretary and the contractor with a basis upon which to judge PRO performance fairly. The process was also to allow the flexibility needed for the Secretary and for the PRO to tailor each contract to local or regional quality and utilization problems. Our intention was not to have objectives established that were so restrictive or so unrealistic as to make achievements of the medically necessary, the sufficient quality, or the cost-effective setting or the accountability criteria—to make achievement of these objectives impossible. This is particularly true with respect to those objectives that relate to quality of care.

At our last hearing of the subcommittee on this subject, concern was expressed that very little attention had been given to quality of care as a PRO objective. Quality is now an element of the contract criteria, but it seems to be expressed—as I review the criteria, and I have had a chance to look at—I don't know if I have seen them all—but some of them—it seems to be expressed almost exclusively in numerical terms. Given the problems that exist with quantifying and measuring this thing called quality of care, I wonder how realistic numerical criteria are. Is it possible to pick up a medical record and determine, on that basis alone, that an individual patient received quality care or that a death was avoidable. Or will a PRO need to also talk to the patient's attending physician, his or her radiologist or pathologist, or nurse before it

can even hope to make a reasonable—much less an absolute—determination?

Shouldn't PRO's also be held accountable for performing those functions which foster quality of care? Since the identification of problems, the education of those providers involved in solving these problems and their corrective action are the kinds of things which assure that the system as a whole ultimately provides the quality care. Recently, we have heard that the contracting process may not provide the results we had envisioned; a lot of that in 1 whole week in Minnesota from at least 60 or 70 mainly rural hospitals. Questions have been raised as to whether the criteria reflect local problems are realistic, or are achievable. We do expect that the PRO's be held accountable—it is the necessary part of this process that Max and I and others helped to design—the question becomes how best to design—the requirements to be met by a PRO and how to measure the PRO's contribution to cost-effective quality care. Now, one of the questions that is somewhat unresolved in my mind, Carolyne, that I trust you will address is that as we designed the prospective payment system with a diagnostic-related grouping base, we assumed in large part that that was designed for a medical marketplace. And that we could expect, if we were to get quality and all the other things at a cost-efficient price, that a PPS system would in effect reward the efficient and provide substantial disincentives to the inefficient. We didn't necessarily expect that a system of numbers was going to sort out the efficients and inefficients, but a system around a prospective payment system would do it. And we expected that among the so-called inefficient and maybe under some of the others that there would be incentives in the prospective payment system—the increased admissions and the increase in the number of early discharges.

I was frankly surprised to find out that the standards for admissions and procedures in particular set out in these contracts don't just say we are going to start where we were and stop the anticipated problems of increased admission and early discharges, but everything that I read on these PRO contracts said we are trying to decrease utilization. And I ran back and looked at the legislation to see if I could find something in the legislation that says, in effect, that you are ordered to use this process to decrease admissions, provide more provision of service outside the hospital.

I don't know that we said that. Clearly, it is great to see that sort of thing happen out there, but the question we are trying to deal with here, I think, is whether in effect a system which does reward the efficient and provide disincentives for the inefficient won't bring about that kind of more appropriate utilization in a more cost-effective setting with appropriate quality of care, rather than expecting you to force a statewide peer review organization to go into a State with a quota system. And frankly, what bothers me about the quota system in what we hope is some kind of a competitive environment, is that the most efficient folks are the ones that are going to have the pressure put on them to come up with what you need to make a quota in that State.

I don't know that that is necessarily the right way we ought to be going about this. I just wanted to raise those as personal concerns gleaned from knowing what I meant when I authored the

legislation on peer review, knowing something about the prospective payment system, having just spent a week sort of hands-on in one State which doesn't yet have a contract, I guess—or maybe they do—and looking over some of the admissions procedures and quality criteria that have been established. I guess I am seeing something to a degree that I didn't expect to see, and what we ought to do here today then is have you tell us why all of this in effect conforms with the objectives in the legislation, and we will let the subsequent witnesses, who represent—and again, a lot of people asked to be witnesses at this hearing—this will not be the last hearing on peer review. It is only the first of many. And so a lot of people we said no to, but we did want to have the Peer Review Organization come in and one specifically, West Virginia—Dr. Harry Weeks—and then the American Hospital Association, which will be represented here today by Jack Owen, and the American Medical Association by Dr. Alan Nelson from Salt Lake, who is one of the founders of PSROs in addition to knowing something about the American Medical Association.

George, do you have a comment you would like to make?

Senator MITCHELL. I have no prepared statement, Mr. Chairman. I think you set the stage very well. The Peer Review Organization program is an important part of our continuing effort to control costs of health care in our society and at the same time to assure its quality. I look forward to Dr. Davis' testimony. I have a number of questions for her, and I join you and I commend you for holding these hearings and whatever prove to be the future hearings on this subject. Thank you.

Senator DURENBERGER. Thank you. Our first witness will be Dr. Carolyne Davis, the Administrator of the Health Care Financing Administration. Carolyne, thank you.

STATEMENT OF DR. CAROLYNE DAVIS, ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Dr. DAVIS. Thank you, Mr. Chairman, and members of the subcommittee. I am pleased to be here today because I think we do need to have a dialog. I believe there is confusion in relationship to what we actually have intended to implement.

I am accompanied today by Mr. Martin Kappert, who is on my right. He is the Associate Administrator for Operations. And on my left is Mr. Philip Nathanson, who is the Director of the Health Standards and Quality Bureau. That is the bureau within which we vest the activities of the Peer Review Organization. I share with the subcommittee a commitment and an interest in ensuring that we do have high quality health care in the hospitals, and that we continue to have that high quality, and furthermore, that we continue to pay for only the care that is appropriate. It seems to me that the avoidance of unnecessary or inappropriate care for our beneficiaries not only saves them from needless suffering but it also assures that we are paying only for needed services. The PRO program, we think, is an integral component in assuring that. I do want to clarify for the record, however, that we don't have quotas. We are not attempting to decrease access to care, and we are definitely not attempting to ration care. Those are comments I keep

hearing. I see them in the headlines. On the contrary, and I think quite to the contrary, what we are intending to do is to monitor the system, to see that the patients do get quality care, and that medicare is not paying for care that is inappropriate or unnecessary. And indeed, I think that in that particular context the dollars that are saved by the medicare program from unnecessary care or from avoidance of inappropriate care are then dollars that we have to give more benefits and provide more care to our beneficiaries—not less. Furthermore, in relationship to the statements about attention to reduce utilization, we have been looking at the actual contracts, and frankly, those contracts focus—at least the ones that I have seen, and I have reviewed a number of them personally—on reduction of inappropriate admissions. I think that we can certainly agree that that is a laudable goal. If indeed in avoiding inappropriate admissions we lead to a decrease in utilization, then in that context, yes. But nowhere do we have specific quotas. We have targets that we are working on with the individual States.

Let me go back, first of all, to talk a bit about the development of the peer review system. As you recognized, when we implemented the prospective payment system, it did of necessity lead us to a somewhat different focus on medical review than we had had previously. And clearly, that has been an enormous challenge for everyone. I think the smoothness with which we have implemented prospective payment this first year is a tribute to the hospitals, the provider community physicians, and to all who have been working to bring this first massive change in reimbursement in the history of the medicare program into being. And I want to continue to assure everyone here that we will continue to work with the various provider groups, just in the way that we have been successful in terms of moving through the initial implementation of prospective payment. We expect to be open and to continue our dialog with the health care industry as we implement the Peer Review Organization Program.

Of necessity, we had to delay the development of the regulations on the Peer Review Organization Program until we had the prospective payment system developed and implemented. Although we could do some concurrent work, clearly the activities that related to prospective payment meant that we were looking at a different type of review system than we had had previously. I think that Congress recognized that factor, too. They had initially asked us to have the Peer Review Organization Program implemented at an earlier date, and recently the legislation under the Deficit Reduction Act extended that time frame to November 15. We have been under a tight timeframe to implement the program in a manner which I believe is both in keeping with the spirit and the letter of the law. The intent of the new provisions, regulations, and contracts is to focus review activities on quality, costs, and utilization. We are asking that the individual organizations identify the specific areas where they believe they are most able to make significant changes.

Let me just review the status of this whole area for a moment or two. We were required to consolidate the existing PSRO areas into PRO areas and to enter into contracts with physician-sponsored organizations or organizations with access to physicians for the pur-

pose of implementing the program. We have a total of 54 Peer Review Organization areas that were designated. We published an NPRM and a final on these designations that include the 50 States, the various territories, and the District of Columbia.

We published the request for proposal [RFP] on February 28 for the PRO areas subject to our prospective payment system, and a separate RFP on April 27 for the states that have developed their own reimbursement system and are therefore exempt from the prospective payment system. Of those that are under the prospective payment system, we have received 54 proposals and we have evaluated those. We found 15 States had proposals that were not technically acceptable, so we published another request for new proposals that were due by July 5. They are now under review. We have actually awarded 26 contracts to date. Several more are in the negotiation phase at this particular point. We expect to be able to complete our entire implementation of PRO contracts in a timely fashion and have them all operational by the November 15 deadline.

Concern has been expressed that we are perhaps being overly demanding in implementation of the PRO contracts. I think the answer to that is clear and simple. We want an effective quality and utilization program. It seems to me that if we look backward and learn anything from history, we recognize the fact that when we initiated the PSRO Program, there was great variation in productivity and great variation in quality of the reviews that were done. Consequently, there was considerable criticism of the effectiveness of that program. And we were determined not to repeat that type of mistake. Therefore, we asked for and Congress directed us to initiate a type of performance-based contract for medical peer review. A performance-based contract, requires some type of outcome target against which we can assess whether or not the individual organization has appropriately performed. What others are viewing as quotas, we are viewing as a negotiable target. When we look specifically at the activities in the PRO scope of work, I think you will find that the following provisions are the ones that are identified We want to have a reduction of admissions for procedures that could be performed just as effectively, and with an adequate assurance of patient safety, in an ambulatory surgical setting or in some type of an outpatient area. We want to also assure ourselves that there is a reduction in the number of inappropriate or unnecessary admissions for invasive procedures for specific DRG's. I would refer you specifically to some data from studies that indicate that there has been a significant number of coronary artery bypass surgeries that are perhaps of questionable value. Likewise, for pacemakers, we can identify various procedures where we have some concerns about overutilization.

Finally, we are asking for a reduction in the number of inappropriate or unnecessary admissions by specific practitioners if that particular utilization pattern has been demonstrated. Occasionally, there is a need for such reduction, and we think that where there is a need, then it is appropriate to target that. I would say those are minimal in numbers. Primarily, we think that the contractor must achieve significant improvement in both utilization and in quality of care. When we published our initial proscope of work, the input that we had from the physician community and others

was that we needed to concentrate more on quality of care outcomes. We have addressed that, and are asking for at least one outcome-oriented quality objective in each one of five specific areas.

In addition, we established evaluation criteria for proposals, which we published as part of the RFP, so the various contractors who were bidding would understand the standards by which we would be evaluating their particular responses. While there has been concern that people don't know what we are evaluating, I thought we were making that quite clear. We have made every effort to try to be open in our activities, although, since it is contract and negotiation work, it is subject to certain bidding activities that preclude public discussions of certain specific parts of it. Nevertheless, I believe that we have been conducting the negotiations in an orderly fashion, and while we have been demanding in some of our negotiations, I think that what we are also saying is that we intend to have flexibility. When the individual contractor gets into operation, if they find that there are differences that need to be recognized, we of course are willing to do so and have stated that to them. We believe, however, that our approach is appropriate since we have to hold the PRO's accountable against some kind of an objective. We have to look at the outcomes. As a practical matter, that doesn't seem to be possible without having some type of an objective that you can actually assess. For example, we couldn't monitor a contract in which we simply had a review organization that would agree to eliminate unnecessary admissions in a particular area without at least being able to say, well, have you accomplished this, by what measurable context? So, we had to have some type of an up-front idea about what we could measure that against.

Let me just refer for a moment to several activities that I think are important and do have some bearing on this whole area. That is the fact that there have been a number of studies recently that indicate there is a significant amount of variation in the type and frequency of medical treatment without any apparent justification and clearly without detriment in the quality of care to the population.

One particular researcher observed that a nationwide study indicated that up to 19 percent of hospital admissions were unnecessary. Another researcher or two have indicated that there is enormous variation in medical practice in various parts of the country related to rates of surgery. They cite specific data relative to parts of the country in such areas as hysterectomies, prostatectomies, and other procedures. Some point to the fact that practice style does vary, and we recognize that. It does indicate then that variation in practice can mean that, with a process of monitoring for quality and utilization, one could embark upon a significant educational program and could expect to have some changes. We think that the physicians in the local medical community are in the best position to judge what the medical review problems are in that particular community, how they want to attack those problems, and what kind of an impact they would expect to achieve. That is why the objectives in the PRO contracts represent what the individual localities' own estimation is of the amount of impact that they can have on unnecessary and inappropriate admissions in their particular area.

Concern has been expressed that the PRO's might take an excessive regulatory approach, and perhaps even emphasize a specific denial pattern. We, I can assure you, would regard that particular activity of continuation of the denial pattern as a failure inside the system because we think of denial as the last-ditch effort. We intend to, as we know the PRO's intend to, rely as much as possible on communication, education, and hands-on working with the physicians and hospitals as they discover those particular problems. That is why the objectives are stated in terms of such activities as fewer complications and fewer invasive procedures.

So, in conclusion, I would just like to say that in creating the prospective payment system, I believe that we made a long-term commitment to changing health care delivery incentives in order to reward efficiency and to continue our cost containment strategy. But what we are looking at here really is an attempt to look at quality of care, to assure ourselves that the quality of care under the prospective payment system is guaranteed, and that, where we can, make cost-effective decisions that relate to avoidance of inappropriate care. I think that the PRO's can meet that particular challenge and we are committed to working with them. Clearly, it is a learning experience as we move through this together. We will set it as a high priority to continue our open dialog.

Let me just close with one final statement, Mr. Chairman. I have been rather concerned in the last few days that the media has focused rather specifically on such issues as reduction of avoidable deaths as a quota activity area. We look upon that, frankly, as simply a proxy, if you will, for increasing quality. I believe that there are only a few instances around the country where there is such a thing as avoidable death. But clearly, even if there is only one, that is an area that we need to tackle. What we need to focus on more, however, is the fact that the majority of this program is looking at other quality indicators such as the avoidance of unnecessary and inappropriate care.

At this point in time, I would be pleased to answer any questions that you might have.

[Dr. Davis' prepared written statement follows:]

STATEMENT OF

CAROLYNE K. DAVIS, PH.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

JULY 31, 1984

INTRODUCTION

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM PLEASED TO BE HERE TODAY TO DISCUSS OUR IMPLEMENTATION OF THE PEER REVIEW ORGANIZATION (PRO) PROGRAM. I AM ACCOMPANIED BY MR. MARTIN KAPPERT, ASSOCIATE ADMINISTRATOR FOR OPERATIONS, AND MR. PHILIP NATHANSON, DIRECTOR OF THE HEALTH STANDARDS AND QUALITY BUREAU. WE SHARE THE INTEREST OF THIS SUBCOMMITTEE IN ASSURING THAT THE RECENTLY ENACTED PROSPECTIVE PAYMENT SYSTEM (PPS), WHICH WAS INITIATED BY THE CONGRESS AND THE ADMINISTRATION, HAS IN PLACE A MECHANISM TO ENSURE THAT HIGH QUALITY MEDICAL CARE IN HOSPITALS CONTINUES TO BE DELIVERED IN THIS COUNTRY AND THAT PAYMENTS CONTINUE TO BE APPROPRIATE. AVOIDANCE OF UNNECESSARY OR INAPPROPRIATE CARE FOR OUR BENEFICIARIES NOT ONLY SAVES THEM FROM NEEDLESS SUFFERING, BUT ALSO ASSURES THAT MEDICARE DOLLARS SUPPORT ONLY NEEDED SERVICES. THE PRO PROGRAM WILL SERVE AS AN INTEGRAL COMPONENT IN OUR PLAN TO ASSURE HIGH QUALITY CARE UNDER THE NEW PPS.

HIGH QUALITY MEDICAL CARE HAS A LONG-STANDING TRADITION IN THIS NATION, AND THIS SUBCOMMITTEE HAS BEEN IN THE VANGUARD OF EFFORTS TO MAINTAIN THIS STANDARD. WE BELIEVE THAT PPS BUILDS UPON THAT TRADITION AND WILL ENABLE US TO CONTINUE OUR COMMITMENT TO ASSURING HIGH QUALITY MEDICAL CARE.

LET ME EMPHASIZE AT THE ONSET THAT THE COMPLEXITY OF THE NEW PAYMENT SYSTEM AND ITS ACCOMPANYING MEDICAL REVIEW REQUIREMENT PRESENT AN ENORMOUS CHALLENGE TO OUR DEPARTMENT. WE HAVE HAD AN EXTRAORDINARY NUMBER OF THINGS TO ACCOMPLISH IN A SHORT PERIOD OF TIME. HOWEVER, IMPLEMENTATION OF PPS IS NOW WELL UNDERWAY AND WE ARE CONFIDENT THAT THE PRO PROGRAM WILL BE IN PLACE BY THE NOVEMBER 15 DATE MANDATED IN THE DEFICIT REDUCTION ACT. FURTHER, WE BELIEVE WE ARE IMPLEMENTING THE PROGRAM IN A MANNER THAT IS IN KEEPING WITH BOTH THE LETTER AND SPIRIT OF THE LAW, AND I COMMEND YOU ON YOUR CONTINUED INTEREST AND IN PROVIDING US WITH THIS OPPORTUNITY TO DESCRIBE OUR PROGRESS.

INITIATION OF PROSPECTIVE PAYMENT

AS YOU KNOW, THE SOCIAL SECURITY AMENDMENTS OF 1983 (P.L. 98-21) CHANGED THE METHOD OF PAYMENT FOR MEDICARE INPATIENT HOSPITAL SERVICES FROM A COST-BASED, RETROSPECTIVE REIMBURSEMENT SYSTEM TO A PROSPECTIVE PAYMENT SYSTEM BASED ON DIAGNOSIS RELATED GROUPS (DRGS). THIS NEW PAYMENT SYSTEM DRAMATICALLY CHANGES PROVIDER INCENTIVES FROM WHAT THEY WERE UNDER RETROSPECTIVE COST BASED REIMBURSEMENT, AND CONSEQUENTLY THE MEDICAL REVIEW ASPECTS ALSO MUST CHANGE FROM WHAT THEY WERE HISTORICALLY WITH THE PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO) PROGRAM. THE PRO AMENDMENTS, WHICH THIS COMMITTEE INITIATED, SET A FIRM FOUNDATION FOR THIS REDIRECTION. THE PRO PROGRAM WILL

REDIRECT, SIMPLIFY, AND ENHANCE THE COST-EFFECTIVENESS OF PEER REVIEW UNDER MEDICARE. THE INTENT OF THE NEW PROVISIONS, OUR REGULATIONS, AND THE CONTRACTS UNDER VARIOUS STAGES OF NEGOTIATION IS TO DIRECT REVIEW ACTIVITIES TOWARD THOSE QUALITY, COST, AND UTILIZATION AREAS MOST LIKELY TO BE AFFECTED BY THE NEW PPS.

STATUS OF PRO IMPLEMENTATION

THE PRO AMENDMENT REQUIRED THE SECRETARY TO CONSOLIDATE EXISTING PSRO AREAS IN THE ESTABLISHMENT OF PRO AREAS AND TO ENTER INTO CONTRACTS WITH PHYSICIAN-SPONSORED ORGANIZATIONS OR ORGANIZATIONS WITH ACCESS TO PHYSICIANS FOR THE PURPOSE OF PRO IMPLEMENTATION. A TOTAL OF 54 PRO AREAS WAS ESTABLISHED THROUGHOUT THE UNITED STATES, INCLUDING THE 50 STATES, THE DISTRICT OF COLUMBIA, PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM (AMERICAN SAMOA AND THE TRUST TERRITORIES OF THE PACIFIC ISLANDS).

A REQUEST FOR PROPOSAL (RFP) WAS PUBLISHED ON FEBRUARY 28 FOR PRO AREAS SUBJECT TO PPS AND ON APRIL 27 FOR AREAS THAT HAVE DEVELOPED THEIR OWN REIMBURSEMENT SYSTEMS AND ARE EXEMPT FROM PPS. PROPOSALS FOR THE PPS AREAS HAVE BEEN RECEIVED AND EVALUATED. OF THE 47 PROPOSALS RECEIVED, THOSE FOR 15 STATES WERE DETERMINED NONRESPONSIVE TO THE RFP AND

THEREFORE UNACCEPTABLE. THE RFP WAS AGAIN PUBLISHED IN THE AREAS WITH NONRESPONSIVE PROPOSALS AND NEW PROPOSALS WERE DUE BY JULY 5, 1984. THESE NEW PROPOSALS ARE NOW UNDER REVIEW. PROPOSALS FOR THE OTHER 32 STATES WERE ACCEPTABLE WITH MODIFICATIONS. OF THESE, 25 CONTRACTS TO DATE HAVE BEEN AWARDED AND MOST OF THE REMAINDER ARE IN NEGOTIATIONS THAT SHOULD RESULT IN CONTRACTS SHORTLY. PROPOSALS FROM PPS-EXEMPT AREAS HAVE BEEN REVIEWED AND THREE WERE DETERMINED TO BE NONRESPONSIVE. THEIR NEW RESPONSES ARE DUE BY AUGUST 16 -- THREE MONTHS BEFORE THE NEW DEADLINE PROVIDED IN THE DEFICIT REDUCTION ACT OF 1984.

I WOULD LIKE TO PROVIDE YOU WITH AN OVERVIEW OF THE WORK REQUIREMENTS WE HAVE SET FOR THE PRO CONTRACTS.

THE PRO SCOPE OF WORK

THE RFP FOR FIXED PRICED PRO CONTRACTS DESCRIBES GENERIC AREAS FOR PRO OBJECTIVES AND REQUIRED REVIEW ACTIVITIES RELATING TO ADMISSIONS, UTILIZATION, AND QUALITY OF CARE, AS WELL AS THE TECHNICAL APPROACH FOR ACCOMPLISHING OTHER REQUIRED ACTIVITIES. WE BELIEVE THIS RFP IS COMPLETELY CONSISTENT WITH STATUTORY INTENT IN THAT IT SETS THE FOUNDATION FOR PERFORMANCE-BASED CONTRACTS, BUT LEAVES TO THE BIDDER THE RESPONSIBILITY TO SPECIFY WHAT PARTICULAR UTILIZATION AND QUALITY ISSUES WILL BE ADDRESSED LOCALLY. IT IS ALSO THE BIDDER'S RESPONSIBILITY TO PROPOSE QUANTIFIED

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PERFORMANCE OBJECTIVES FOR ADDRESSING THESE ISSUES. WITHIN BROAD GUIDELINES IT IS ALSO THE BIDDER'S RESPONSIBILITY TO DEVELOP THE PROCEDURES FOR MEETING THESE OBJECTIVES. THUS, ALTHOUGH THE RFP SPECIFIED THE OBJECTIVES TO BE MET, THE BIDDERS SPECIFIED THE AMOUNTS TARGETED FOR CHANGE, BASED ON COMMUNITY NEEDS AND PRACTICES. THE SCOPE OF WORK CONTAINED THE FOLLOWING MAJOR PROVISIONS:

I. ADMISSION AND PROCEDURE OBJECTIVES

-- REDUCTION OF ADMISSIONS FOR PROCEDURES THAT COULD BE PERFORMED EFFECTIVELY AND WITH ADEQUATE ASSURANCE OF PATIENT SAFETY IN AN AMBULATORY SURGICAL SETTING OR ON AN OUTPATIENT BASIS.

-- REDUCTION OF THE NUMBER OF INAPPROPRIATE OR UNNECESSARY ADMISSIONS OR INVASIVE PROCEDURES FOR SPECIFIC DIAGNOSIS RELATED GROUPS. AN EXAMPLE IS THE REDUCTION OF THE NUMBER OF LENS PROCEDURES WHERE THE VISUAL ACUITY DOES NOT JUSTIFY THE PERFORMANCE OF THE PROCEDURE ON AN INPATIENT BASIS.

-- REDUCTION OF THE NUMBER OF INAPPROPRIATE OR UNNECESSARY ADMISSIONS OR INVASIVE PROCEDURES BY

SPECIFIC PRACTITIONERS OR IN SPECIFIC HOSPITALS WHEN THEIR UTILIZATION PATTERNS DEMONSTRATE SUCH A NEED.

II. QUALITY OBJECTIVES

THE CONTRACTOR MUST ACHIEVE SIGNIFICANT IMPROVEMENT IN PATIENT CARE QUALITY. AT LEAST ONE OUTCOME-ORIENTED QUALITY OBJECTIVE IS REQUIRED IN EACH OF THE FOLLOWING AREAS:

-- REDUCTION OF UNNECESSARY HOSPITAL READMISSIONS RESULTING FROM SUBSTANDARD CARE PROVIDED DURING THE PRIOR ADMISSION;

-- ASSURANCE OF THE PROVISION OF MEDICAL SERVICES WHICH, WHEN NOT PERFORMED, HAVE "SIGNIFICANT POTENTIAL" FOR CAUSING "SERIOUS PATIENT COMPLICATIONS";

-- REDUCTION OF <u>AVOIDABLE</u> DEATHS;

-- REDUCTION OF UNNECESSARY SURGERY OR OTHER INVASIVE PROCEDURES; AND

-- REDUCTION OF AVOIDABLE POST-OPERATIVE OR OTHER COMPLICATIONS.

IN ADDITION TO ADMISSION AND QUALITY OBJECTIVES, WHICH ARE BASED ON IDENTIFIED AND VERIFIED PROBLEMS IN A PRO AREA, THE CONTRACT WILL ALSO REQUIRE THE FOLLOWING ACTIVITIES IN PPS AREAS:

-- ADMISSION REVIEW,

-- PREADMISSION REVIEW,

-- REVIEW OF SPECIALTY HOSPITALS (E.G., PSYCHIATRIC, LONG-TERM CARE, CHILDREN'S, AND REHABILITATION HOSPITALS),

-- INVASIVE DIAGNOSTIC AND THERAPEUTIC REVIEW, (E.G., REVIEW OF ALL CARDIAC PACEMAKER IMPLANTATIONS),

-- OUTLIERS REVIEW

-- DRG VALIDATION

-- DEVELOPMENT OF SANCTION RECOMMENDATIONS,

-- REBUTTAL OF THE FAVORABLE PRESUMPTION OF LIABILITY, AND

-- REVIEW OF EVERY HOSPITAL TRANSFER.

IN THE NON-PPS AREAS, QUALITY OBJECTIVE REQUIREMENTS ARE BASICALLY THE SAME AS THOSE FOR THE PPS AREAS. THE OTHER REQUIRED REVIEW ACTIVITIES, HOWEVER, HAVE BEEN ADAPTED TO THE CHARACTERISTICS OF THE INDIVIDUAL NON-PPS AREAS. ANY CASES WITH PRINCIPAL DIAGNOSES WHICH ARE NOT USUALLY INDICATIVE OF A JUSTIFIED ADMISSION WILL BE REVIEWED ON A PREADMISSION BASIS IN PPS AREAS AND NON-PPS AREAS.

IN ADDITION TO THE SCOPE OF WORK, WE ALSO ESTABLISHED A SET OF EVALUATION CRITERIA WHICH WERE PUBLISHED AS PART OF THE RFP SO THAT BIDDERS WOULD KNOW THE STANDARDS BY WHICH WE WOULD EVALUATE THEIR RESPONSES. EVERY EFFORT IS BEING MADE TO ENSURE BOTH THOROUGH AND FAIR EVALUATIONS. FORTY-SEVEN PANELS WERE CREATED TO REVIEW PROPOSALS. THESE PANELS WERE COMPOSED OF TWO CENTRAL OFFICE STAFF, FOUR REGIONAL OFFICE STAFF, AND A MEDICAL CONSULTANT AS NEEDED.

CONTRACT NEGOTIATIONS

OUR CONDUCT OF THESE NEGOTIATIONS, AND THE DETAILS OF SOME OF THE CONTRACTS WE HAVE ALREADY SIGNED, HAS CAUSED SOME CONCERN WITHIN THE HOSPITAL COMMUNITY AND ELSEWHERE. IT HAS BEEN SUGGESTED THAT WE HAVE BEEN OVERLY DEMANDING AND SPECIFIC IN THE NEGOTIATIONS; THAT PROS WILL IMPOSE "QUOTAS"

ON ADMISSIONS WHICH WILL REDUCE ACCESS TO CARE; AND THAT OUR APPROACH IS OVERLY REGULATORY AND RELIES TOO HEAVILY ON DENIALS TO ACHIEVE ITS PURPOSES. LET ME ADDRESS EACH OF THESE CONCERNS BRIEFLY.

FIRST, WE HAVE INDEED BEEN DEMANDING IN OUR NEGOTIATIONS. THE PRO PROGRAM -- WITH ITS EMPHASIS ON "UP-FRONT" NEGOTIATION OF OBJECTIVES EMBODIED IN A PERFORMANCE CONTRACT -- WILL ALLOW US TO EVALUATE HOW WELL PEER REVIEW PERFORMS. IN FACT, WE HAVE BEEN SURPRISED AT THE AMBITIOUS OBJECTIVES MANY OF THE BIDDERS HAVE PROPOSED. THE UTILIZATION AND QUALITY OBJECTIVES IN THE PRO CONTRACTS WILL CERTAINLY REQUIRE THE PROS' BEST EFFORTS TO ACHIEVE. BUT BOTH WE AND THE PROS BELIEVE THEY ARE ACHIEVABLE.

WE ARE ALSO REQUIRING PROS TO SET SPECIFIC NUMERICAL OBJECTIVES. WE BELIEVE THIS APPROACH IS INHERENT IN THE STATUTORY MANDATE THAT, RATHER THAN BECOME INVOLVED IN DAY-TO-DAY MONITORING OF PRO MANAGEMENT, WE HOLD PROS ACCOUNTABLE AGAINST OBJECTIVES. AS A PRACTICAL MATTER, IT IS NOT POSSIBLE TO MONITOR PROGRESS AGAINST OBJECTIVES THAT DO NOT HAVE SPECIFIC MILESTONES (E.G., ONE COULD NOT MONITOR A CONTRACT IN WHICH A PRO AGREED TO ELIMINATE UNNECESSARY ADMISSIONS FOR LENS PROCEDURES THAT COULD BE PERFORMED ON AN OUTPATIENT BASIS, WITHOUT HAVING AN IDEA "UP FRONT" OF HOW MANY UNNECESSARY ADMISSIONS THERE MIGHT BE). EVEN THOUGH WE

ARE BEING SPECIFIC IN THE CONTRACTS, WE DO NOT INTEND TO BE RIGID OR INFLEXIBLE IF WE LEARN, DURING THE COURSE OF THE CONTRACT, THAT THE NUMBERS SHOULD BE MODIFIED. WE ARE ALWAYS READY TO RENEGOTIATE WITH THE PROS IF WE OR THEY LEARN, FOR EXAMPLE, THAT THEY HAVE OVERSTATED THE NATURE OF A PARTICULAR PROBLEM, OR IF THEY HAVE IDENTIFIED A MORE PRESSING PROBLEM FOR REVIEW, OR EVEN IF THE STATISTICS THEY USED TO DEVELOP THE OBJECTIVE IN QUESTION WERE INCORRECT.

I ALSO WANT TO ASSURE YOU THAT THESE SPECIFIC OBJECTIVES ARE NOT "QUOTAS". ALL ADMISSION OBJECTIVES FOCUS ONLY ON UNNECESSARY AND INAPPROPRIATE CARE, NOT ON REDUCTIONS IN OVERALL ADMISSIONS. PROS WILL DENY NO ADMISSIONS THAT ARE NECESSARY AND APPROPRIATE BASED ON LOCAL AND REGIONAL STANDARDS OF PRACTICE FOR THE PRO AREA.

MR. CHAIRMAN, MANY KNOWLEDGEABLE PEOPLE BELIEVE THERE IS SERIOUS OVERUTILIZATION IN HOSPITALS TODAY. AT A RECENT NATIONAL ACADEMY OF SCIENCES SEMINAR THERE WAS MUCH DISCUSSION OF THE HUGE VARIATIONS IN THE TYPE AND FREQUENCY OF MEDICAL TREATMENTS WITH NO APPARENT JUSTIFICATION. ONE RESEARCHER OBSERVED THAT NATIONWIDE STUDIES OF MEDICARE HAVE INDICATED THAT UP TO 19 PERCENT OF HOSPITAL ADMISSIONS ARE UNNECESSARY. WE BELIEVE -- AS I KNOW THE MEMBERS OF THIS

SUBCOMMITTEE DO -- THAT PHYSICIANS IN THE LOCAL MEDICAL COMMUNITY ARE BEST ABLE TO JUDGE WHAT THE MEDICAL REVIEW PROBLEMS ARE WITHIN THE COMMUNITY, HOW TO ATTACK THEM, AND HOW MUCH IMPACT IT IS POSSIBLE TO ACHIEVE. THE ADMISSIONS OBJECTIVES IN THE PRO CONTRACT REPRESENT EACH PRO'S OWN ESTIMATE OF THE AMOUNT OF IMPACT IT CAN HAVE ON UNNECESSARY AND INAPPROPRIATE ADMISSIONS IN ITS AREA. CERTAINLY, HCFA HAS INSISTED THAT THE PROS STRETCH THEMSELVES IN DEVELOPING THESE OBJECTIVES, BUT THE SPECIFIC STRUCTURE OF THE OBJECTIVES AND THE NUMERICAL GOALS HAVE BEEN DEVELOPED BY THE PROS.

I WOULD LIKE TO COMMENT BRIEFLY ON HOW THE PROS WILL ACCOMPLISH THESE OBJECTIVES. CONCERN HAS BEEN EXPRESSED THAT PROS WILL TAKE AN EXCESSIVELY REGULATORY APPROACH, PERFORMING MEDICAL REVIEW ON A CASE-BY-CASE BASIS WITH AN EMPHASIS ON DENYING ADMISSIONS. I CAN ASSURE YOU THAT THE PROS, AND HCFA, WILL REGARD DENIALS AS FAILURES OF THE SYSTEM. THE PROS WILL RELY AS MUCH AS POSSIBLE ON COMMUNICATION, EDUCATION, AND "HANDS-ON" WORKING WITH PHYSICIANS AND HOSPITALS AS PROBLEMS ARE DISCOVERED. THIS IS WHY ALL OBJECTIVES ARE STATED IN TERMS OF RESULTS -- E.G., FEWER COMPLICATIONS, LOWER READMISSION RATES, FEWER INVASIVE PROCEDURES -- RATHER THAN IN TERMS OF DENIAL RATES. SUPPOSE, FOR EXAMPLE, A PRO SETS ITSELF THE TASK OF REDUCING

THE NUMBER OF READMISSIONS FOR COMPLICATIONS AFTER MAJOR JOINT PROCEDURES BY "X" NUMBER OF CASES. IF IT CAN ACHIEVE THAT REDUCTION DURING THE COURSE OF THE CONTRACT WITHOUT DENYING A SINGLE READMISSION, THAT WOULD BE OPTIMUM PERFORMANCE AS FAR AS WE ARE CONCERNED.

CONCLUSION

MR. CHAIRMAN, IN CREATING THE PROSPECTIVE PAYMENT SYSTEM, CONGRESS AND THE ADMINISTRATION MADE A LONG-TERM COMMITMENT TO CHANGING INCENTIVES IN THE HEALTH CARE SECTOR TO REWARD EFFICIENCY AND COST CONTAINMENT. IN ADDITION, IN ORDER TO ASSURE THAT HIGH QUALITY PATIENT CARE CONTINUES TO BE PROVIDED TO OUR BENEFICIARIES, THE CONGRESS PUT A STRONG MECHANISM IN PLACE TO ASSURE THAT QUALITY IS MAINTAINED. WE BELIEVE THAT THE VAST MAJORITY OF PHYSICIANS AND HOSPITALS WILL CONTINUE TO PROVIDE HIGH QUALITY AND APPROPRIATE CARE. HOWEVER, IT IS OUR RESPONSIBILITY TO ASSURE THAT THIS IS THE CASE. EACH PRO WILL BE OBLIGATED TO CONDUCT MEANINGFUL QUALITY REVIEW AND ACHIEVE SIGNIFICANT IMPACT ON THE QUALITY OF CARE FURNISHED TO MEDICARE BENEFICIARIES IN ITS AREA.

WE BELIEVE THAT THE PROS CAN MEET THIS CHALLENGE AND BECOME AN INTEGRAL PART OF THE NATION'S TOTAL HEALTH CARE SYSTEM.

CLEARLY, THERE IS MUCH TO LEARN AS EXPERIENCE WITH PROSPECTIVE PAYMENT AND MEDICAL REVIEW GROWS, AND WE EXPECT THE PROGRAM TO IMPROVE WITH TIME. BUT THIS I ASSURE YOU: THE HEALTH CARE FINANCING ADMINISTRATION HAS SET A HIGH PRIORITY ON DEVELOPING AND IMPLEMENTING AN EFFECTIVE MEDICAL REVIEW SYSTEM WHICH WILL EXAMINE BOTH THE COST AND QUALITY OF CARE.

I HOPE YOU HAVE FOUND MY COMMENTARY USEFUL IN UNDERSTANDING HOW WE ARE APPROACHING QUALITY ASSURANCE ISSUES IN THE CONTEXT OF IMPLEMENTING MEDICAL REVIEW UNDER THE NEW PPS. I WILL BE PLEASED TO ANSWER ANY QUESTIONS YOU MIGHT HAVE.

Senator DURENBERGER. OK. Thank you very much. I am going to try to keep this as brief as I can until we can hear from the rest of the witnesses. Quickly, but let me deal first with the early part of your statement which says that this isn't quotas and this isn't rationing. So, I have to ask the question, then, what is an objective in your sense? They are not specifically called quotas—you are too smart to do that. And it is not called rationing because we are deliberately trying to avoid that. But they are called objectives, and they are called admission objectives, and they are called procedural objectives and quality objectives, as I see them outlined in these contracts.

Now, while I was writing that question down here to ask you, I think I heard you answer it. You said something like it is a target that is negotiable.

Dr. DAVIS. That is correct.

Senator DURENBERGER. So, I need to ask you two questions. One, why have only 26 of the 54 States have PRO's by now? And doesn't it have something to do with whether or not they can have confidence in a target that is negotiable that looks very, very specific? And then second, try to assure us how you get the benefit of some measurable negotiated objectives within the theory of a target that is negotiable. How do you think you are accomplishing that?

Dr. DAVIS. Let me start back with the whole purpose of an objective because it seems to me that in any line of work, one wants to be measured by what he accomplishes or performs, and I think most people when they go into a work situation would clearly indicate that they have a set of priorities that they want to accomplish. Generally speaking, when you put those down, those are regarded as objectives. The more specific you are, the more you can be evaluated against those accomplishments, and we felt that by asking for a degree of specificity, it allowed us to be able to then look at the accomplishments of the particular organization. Again, going back to the fact that in the past, we have had a variety—certainly in terms of the effectiveness of the past programs—in terms of utilization review activities. It was an attempt to be able to have some kind of assessment protocol with which we could then target our review of their accomplishments that led us to ask for specific objectives.

Senator DURENBERGER. Let me then try to get real specific and maybe both of you can chime in here. I am going to start with South Carolina. From July 1, 1984, through June 30, 1986, reduced by 50 percent the number of medicare patients admitted to South Carolina hospitals for surgery, which can be safely performed in an outpatient basis. Just tell us how that got arrived at and how you are going to hold their feet to the fire.

I hope I picked a simple one for starters.

Mr. NATHANSON. In our discussion with South Carolina—as we did with all the Peer Review Organizations—we asked them to look at their practices of medical care and at their utilization, and asked them to tell us what kinds of admission objectives they could do and what level they could accomplish. We actually had very little negotiation with South Carolina. As you may know, that was the first contract signed. We were quite happy, in fact, with their idea of what could be accomplished in the way of unnecessary and

inappropriate care reductions, and we accepted their objectives basically—although we did, as always in the Government in negotiation, ask questions and so forth. This, like the other objectives that we received represents their estimate, negotiated with us, as to what they believe they could accomplish in the way of surgery that can be safely done on an outpatient basis.

Senator DURENBERGER. All right. Then, their second admission objective relates to specific DRG's—294, 295, 296, 297, and 298—which they intend to reduce by 25 percent or 882 admissions the number of inappropriate medicare admissions, apparently from a July 1, 1984 base.

Mr. NATHANSON. Yes. They have done studies which indicate to their satisfaction that there is room to reduce admissions for these particular DRG's.

Senator DURENBERGER. All right. So, you didn't pick out the DRG's—or who picked out the DRG's?

Mr. NATHANSON. In terms of the scope of work, we gave them a number of DRG's that we talked about for preadmission reviews, but we allowed them to pick DRG's for inappropriate medicare admission reductions in general. This is in effect their selection of DRG's for that.

Senator DURENBERGER. Their selection?

Mr. NATHANSON. Their selection.

Senator DURENBERGER. But it comes off of a list that you gave them?

Mr. NATHANSON. Some of them do. Some of them don't.

Senator DURENBERGER. Which ones don't?

Mr. NATHANSON. I don't know.

Senator DURENBERGER. Well, there are only a few of them. They must all be related; 94 through 98. What are they? I don't know all these numbers.

Mr. NATHANSON. OK. We had given them a list of DRG's that we believed lent themselves to preadmission reviews such as lens extractions and a number like that. Some of these may be off that list, and some may not.

Senator DURENBERGER. Then, under quality objectives—and I am trying not to spend a lot of time on these specifics—just so that I understand how you went about it—under quality objectives, there is a variety of reducing the incidence of unnecessary surgery.

Mr. NATHANSON. Right.

Senator DURENBERGER. And there you have 39—which is the interocular lens—and the permanent cardiac pacemaker implant with AMI or CHF, and the permanet cardiac pacemaker implant without it, et cetera. And again, this I take it is through preadmissions——

Mr. NATHANSON. No, not necessarily. In fact, one of the concerns that has been expressed is that this is a program that relies heavily on denial and on intense review. In fact, the way we hope to accomplish these quality objectives is by telling the hospital—the Peer Review Organization will tell the hospital—what it is committed to in the area of quality and the protocol that it is looking for in terms of quality improvement. In every one of these cases, the Peer Review Organization has identified and demonstrated for us a problem with the practice pattern of particular hospitals or in the

State as a whole that can be prevented by the physicians working with the Peer Review Organization and following protocols that have been developed as provided in the legislation, tailored to the local care practices. So, what the PRO intends to do is to publish that protocol, to tell the hospitals that in fact it expects the hospitals to be using those protocols in viewing these problems, and that it will hold the hospitals accountable.

What we hope is that we don't have to deny any. We hope the PRO's by doing that will be working with the hospitals so they change their behavior to eliminate the particular problem.

Senator DURENBERGER. Well, I shouldn't worry about whether one of these things shows up under a quality objective or an admission objective then?

Mr. NATHANSON. There is quite a bit of overlap, in fact, between the quality objective and the admission objective.

Senator DURENBERGER. That is my problem. I am trying to understand. I am trying to put myself out there and try to figure out how the system operates. When I see a pacemaker without an AMI or a CHF in one State being an admission objective and in another State being a quality objective, I shouldn't worry about that, because the message that the PRO is taking back to the hospitals is the same in both cases?

Mr. NATHANSON. Right. Yes. Correct.

Senator DURENBERGER. OK. Now, another question that relates to this. I said in my opening statement that we could have started where we were in 1984 and just said don't let it rise. Everything you have been testifying to here so far—and that I have been asking you about—takes the system down.

Dr. DAVIS. Keep in mind that we are speaking of inappropriate admissions. In other words, I think it would be a lack of good administration to allow the medicare program to continue to reimburse for admissions that are not necessary.

Senator DURENBERGER. No, to me there are two ways to look at an inappropriate admission. One is it is inappropriate from a 1984 base, given this new prospective payment system. We see this hospital starting to admit a lot of people under a bad diagnosis that they didn't admit before, and you are saying, no, there is an added dimension to it which is—starting in 1984—there was a lot of inappropriate admissions and we have got to try to sort that out.

Dr. DAVIS. Let me give you a specific example, and perhaps that will help us. In one particular State, they indicated that the rate of readmissions after a particular procedure for a joint procedure—generally a hip replacement or something of that nature—was about 10 percent of the patients. In other words, after they had had that surgery and were sent home, they would come back with some kind of a complication. The national rate was about 4 percent. Now, that would tell you that there is room for improvement. They identified that as one of their goals, and we agreed with them that that was appropriate.

Now, to the degree that they are successful in their educational program so that they drive down the numbers of individuals who have complications who need to return, then that is a reduction in overall utilization.

Senator DURENBERGER. In whose educational program?

Dr. DAVIS. It would be the Peer Review Organization that would be conducting an educational program with the hospital personnel.

Senator DURENBERGER. I hate to get too far off course here, but when does that start—after you get your contract?

Dr. DAVIS. Yes.

Senator DURENBERGER. Because I know it is not happening in my State.

Mr. NATHANSON. No. It does happen immediately when the PRO begins its medical review activities, and this gets back to something that you were saying in your opening statement. We would like to see the PRO's being a positive force for improving quality. That is precisely what these objectives are trying to do. We are not trying to be punitive or negative here. What we are trying to do is to say that the physicians in this area have identified practice problems. These are things that you can do to resolve them. The Peer Review Organization will be working with you to resolve it, and we all expect that this will result in fewer of the kinds of problems that you have. And the objective is an expression of that kind of a belief. It is not a quota.

Senator DURENBERGER. OK. So, variations in types of treatments and medical care that we find all over the place are being identified and have been identified in various ways by peers, which is one of the reasons why we wanted peer in the review process. Right?

Dr. DAVIS. That is right.

Senator DURENBERGER. That is the theory because all of these smart guys are out there watching their peers cut people open that shouldn't be cut open.

Now, tell me just briefly how the process of coming up with these State specific objectives is accomplished. To what degree are the hospitals and the physicians and/or existing PSRO's and whatever else may exist in the State—how have they been involved in the process of determining with such specificity which variations and types and treatments of medical care are going to be addressed in that State?

Dr. DAVIS. In the requests for proposals that went out, clearly any medical organization that met particular criteria could submit a proposal, and indeed in some States we had two or three various medical entities that submitted proposals. In other States, we only had one. They clearly needed to have data from their own local areas, and many of these conducted studies that related to particular issues in their own area. They speak about those studies when they submit their particular proposals.

Mr. NATHANSON. We didn't mandate any particular process by which they gathered the information. Some of them were affiliated with or had been PSRO's before. Some of them had access to quality studies. Some of them did in fact talk to individual hospitals and physicians to develop these. What we required was that the studies be valid, be reasonable, and be capable of building an objective.

Senator DURENBERGER. Do you have any process of qualifying the peers in the Peer Review Organization?

Mr. NATHANSON. Yes.

Senator DURENBERGER. How? Can you describe it briefly?

Mr. NATHANSON. Yes. A Peer Review Organization, when it submits its proposal, must tell us who the physician consultants are to the Peer Review Organization. There is a requirement that we have that peers' review; in other words, that we have sufficient numbers of specialty physicians to review specialty cases, and that we have a sufficient number to meet the representativeness and the substantial requirements that were put in the legislation.

Senator DURENBERGER. When you get those, do you get names back?

Mr. NATHANSON. We get names and we get CV's.

Senator DURENBERGER. Do you run them through those computers you have up there in Baltimore to find out which ones are the overutilizers, if that is the case? [Laughter.]

Mr. NATHANSON. It hadn't occurred to us until now. [Laughter.]

Senator DURENBERGER. I mean, if the administrator is using all these studies that we have all seen about practice patterns, we know that in one town they are taking tonsils out from the first time they get a throat ache, and in the next town everybody still has their tonsils. Now, if a peer from the first town is assessing the medical necessity of treatments of people in that same town, what have we accomplished?

Mr. NATHANSON. We require, as you did in the legislation that the peer review folks be representative of doctors in the area and substantial. We believe that by meeting those tests of representativeness and substantiality that we have controlled for that sort of problem.

Senator DURENBERGER. What hospital involvement is there required in each of these contracts in coming up with objectives?

Mr. NATHANSON. There is none required. However, many of the Peer Review Organizations have taken advantage of discussion with local hospital groups.

Senator DURENBERGER. I have a slug of other questions, and I also have some other questions which Senator Long wants to be sure to have you respond to. But on the issue of the avoidable deaths for the elderly, would you explain a little bit about why an intrusion into a person over 65 might not be as appropriate as an intrusion into a person under 65 and in what cases? I think we tend to assume that certain of these procedures are appropriate regardless of age and that when you do start talking across this country about avoidable deaths, you may really be talking about avoidable intrusions into elderly bodies, which is a concept that I don't think most people in this country understand.

Dr. DAVIS. That is correct. Because very frequently there is a risk that is attached to a surgical procedure. It may be very slight, but any time that you are putting a patient under anesthesia and are also opening the body cavity, you are subjecting that body to stresses that are in addition to what it is normally coping with, and many of the elderly patients have more than one problem. So, you might, for example, suggest that the cure for the patient is to have a hysterectomy, but that means that you are subjecting that individual who may also have a problem with, say, diabetes and several other problems—hypertension or something like that—to additional stresses. It may be preferable to reassess that particular patient and say this is not a malignancy. Therefore, it can be handled

in a less aggressive manner. It is those kinds of subjective decisions that have to be made by the medical practitioner, but since we know that those kinds of judgments seem to vary widely across the country, as documented by the various studies, then it suggests to us that there is a need for an educational program to look at this. Once they have made that kind of medical judgment, then it is appropriate for them. What we have intended in this review process is that before an actual denial can be made, the physician on the Peer Review Organization must actively discuss the case with the attending physician who handles that case. So, it allows for a peer exchange, if you will, before any final decision is made.

Senator DURENBERGER. We see an awful lot of heart or coronary—cardiac, whatever the magic words are—in all of these objectives, and most of it would seem to send a message to the elderly people in this country that they are either having too many revised coronary artery bypass graph procedures or coronary bypass graph procedures without left main artery involvement where less than a three-vessel graph was completed, or whatever, than is necesary or that may be some of this is dangerous to their health. Is there some of both of those messages?

Dr. DAVIS. I think that there have been research studies that indicate that there are excessive coronary artery bypass surgeries. Just as we know that there is inappropriate use of pacemakers implanted at times, too. Since the elderly tend to have many heart problems, I think it is understandable that many of the objectives do focus in the area of the heart. Particularly understandable is the fact that they are targeting on coronary artery bypass since it clearly is an area which has been identified by medical judgment as an area where there is overuse of the surgical procedures. Perhaps medical treatment could be used more effectively. Obviously, when you are opening up the heart and putting a patient on a heart-lung machine, that is a significant procedure. You are then subjecting that person to the perils of anesthesia, risk, concomitant infections, blood transfusions—any one of which could imperil his life.

Senator DURENBERGER. Thank you. George.

Senator MITCHELL. Thank you very much, Mr. Chairman. Dr. Davis, you stated very emphatically at the outset that the numerical data elicited and contained in the proposals are not quotas, rather are goals and objectives and you used those phrases repeatedly in your comments here today.

Now, of course, what is a quota as opposed to a goal could be like what is beauty? That is, it may be a subjective determination in the eye of the beholder. One significant method of distinguishing between the two is to ask what happens if the numerical figure is not achieved. What will happen if, let's say, a reduction of 25 percent of a certain procedure or result as contained in one of these proposals which you approve is not attained during the prescribed period.

Dr. DAVIS. What we would do would be to sit down with that particular Peer Review Organization and ask them if they have a rationale for why it wasn't. Let's say that they said that in looking they found this wasn't really a problem in their community. We thought it was and when we began to actually do the reviews, it

wasn't a problem here, ergo we simply couldn't accomplish that. That is very bona fide, and it may be that they will discover that early on. They might turn to us partway through the year and say, look, you know, that particular objective that we thought we were going to be able to do something with, we aren't going to be able to. We would say fine. On the other hand, they may say this: We did not accomplish a 26-percent reduction, but we were able to accomplish 10 percent, and we would say that is great progress. Let's keep working on that. If on the other hand they said this really is a problem, but we have been able to do nothing with it, then we would want to go in and sit down with them and find out why the educational programming wasn't working. Would we need to move to an actual denial of the admissions in order to emphasize that there needed to be significant attention given to it? I think we have to work out each one of those individually. It is simply a mark by which we can examine progress.

Senator MITCHELL. Therefore, is it safe to assume that in no instance will someone's reimbursement be denied on the grounds that they failed to achieve the objectives set forth in the proposal?

Dr. DAVIS. I think I couldn't say that because if they failed to achieve any objectives that they set forward, we certainly wouldn't want to pay them for doing nothing.

Senator MITCHELL. And so, therefore, that means that whether or not this particular objective is a goal or a quota, in fact is a subjective judgment to be made by you or your designee at some future point.

Dr. DAVIS. I think what we have tried to say, Senator Mitchell, is that we need to look at these as targets so that we can feel that for what we are paying, they are accomplishing something. I would assume that the majority of these individuals, knowing that they are going to be looked at, will be working toward that. But it will be a mutual relationship. It doesn't mean that if they have accomplished a certain percentage and we said it was 2 percent more in the contract that that meant that they failed and we weren't going to give them money. On the contrary, you have to look at the entire spectrum of what they have done. I think we would be very derelict, however, if we allowed somebody to continue that was accomplishing nothing.

Senator MITCHELL. So, is it fair then to say that you reject two extremes? First that failure to achieve the numerical objective or quota or whatever you call it will not automatically result in failure of reimbursement. The other extreme—inability to achieve an objective—will or may carry the penalty of reimbursement depending upon the particular circumstances in each case. Is that a fair——

Dr. DAVIS. That is fair to say, but I would stress that it is failure to achieve many of the objectives, not a single one. It is looking at what their overall accomplishments are.

Senator MITCHELL. So, when the phrase is used—and I am sure you saw the article that appeared in the New York Times on July 29, describing the contracts using the phrase repeatedly "acquires and must"—which suggests to the ordinary reader a penalty for failure to achieve that objective. You are saying that is not correct. There is not necessarily a penalty attached to it. It depends upon

the extent by which the objectives are not met, how many objectives are not met, the reasons for the failure to meet them, and the ability to correct them if there are valid reasons.

Dr. DAVIS. That is correct.

Senator MITCHELL. And that is all subject to subsequent determination based upon what happens. Is that a fair statement?

Dr. DAVIS. That is.

Senator MITCHELL. Now, you state in your written testimony that of the 47 proposals received, those for 15 States were determined to be nonresponsive and you state they had submitted new proposals. Are there any States in which of that category of initial rejections of 15 have been rejected a second time?

Dr. DAVIS. Yes, sir, there are several, I believe.

Senator MITCHELL. Could you identify them, please?

Dr. DAVIS. I am sure that one that you are interested in is Maine.

Senator MITCHELL. I was going to be more specific. [Laughter.]

Dr. DAVIS. I am informed that that is the only one that presently knows that they have failed. There are a couple of other ones.

Senator MITCHELL. Before I proceed along that line of inquiry, let me ask a more general question. As I understand it, the failure of a PRO to gain approval of its proposal by a certain time will result in the fiscal intermediary automatically becoming the PRO. Is that correct?

Dr. DAVIS. That is correct. That is a statutory requirement.

Senator MITCHELL. Do you know—have you had any analysis or estimate made—of the relative cost to the medicare program of this service being performed by a PRO as opposed to a fiscal intermediary?

Dr. DAVIS. I don't know if we have had an analysis done, but I think it would probably be similar in cost, but we have been focusing all of our energies on bringing up the Peer Review Organizations. In the case of the several States that have failed the second time, we intend to go out with yet another RFP and hope that this time they will really believe we are serious. We had significant improvement. The first 15—or several of the first 15—were rather sloppily put together. One organization didn't even address the appropriate State in the case where it was bidding for several States.

However, they certainly improved dramatically the second time around. We have a bidder's conference debriefing when we want to go through the proposals and tell them specifically what we see the problems are in order to encourage resubmission. So, it is our intent to do that again.

Senator MITCHELL. Is it therefore accurate to describe your policy as attempting affirmatively to get a PRO functioning in each of the States where proposals have been submitted?

Dr. DAVIS. Yes, it certainly is.

Senator MITCHELL. You are trying to work it out with them rather than having this fall by default upon the fiscal intermediary?

Dr. DAVIS. Yes, sir, but if in the end, by November 15, we have not been able to achieve that, then we will have to turn to a fiscal intermediary.

Senator DURENBERGER. That is another branch of the administration that wants fiscal intermediaries.

Senator MITCHELL. I am aware of that, and that is why I am frankly delighted to hear your comment and I am accepting what you say at face value and expect that you will pursue that policy aggressively, notwithstanding any effort by anybody else.

Dr. DAVIS. Yes, sir. [Laughter.]

Senator MITCHELL. Thank you. Now, are you familiar with the Maine application?

Dr. DAVIS. I am slightly familiar with it. I think that Mr. Nathanson is intimately familiar with it.

Senator MITCHELL. All right.

Dr. DAVIS. Between the two of us, we can probably answer your specific concerns.

Senator MITCHELL. Mr. Nathanson, could you describe for me, please, as concisely but as accurately as you can the reasons for the second denial?

Mr. NATHANSON. There are two major problems, Senator Mitchell. One was with the objectives themselves. As Dr. Davis has mentioned, we require in an objective a statement of a problem that has been determined by the offeror to exist, a statement of what the offeror intends to do about the problem and how much impact it should have. The problem with the objectives proposed by Maine was that they did not have any baseline measurement. They did not state exactly what they were going to do about the problem nor did they state any kind of a target so that we could tell whether, in fact, they had had any successful intervention. That was true both of their admissions objectives and their quality objectives.

The other problem that they had was with the experience of the staff. As far as the staff was concerned, there was only one person on the proposed management team that had the necessary medical review experience. There were also some data processing problems. The data processing subcontract didn't appear to have the experience either. So, I guess you could say it was both the objectives and the experience of the management team that made it so that we didn't feel that we could do business with the proposal as submitted.

Senator MITCHELL. I would call to your attention, Mr. Nathanson, and I understand you must perform your duties consistent with the objectives of the law, and I don't mean to suggest that you do anything but that, but I would call to and ask you to consider that Maine was one of only six States that did not have a functioning PSRO.

Mr. NATHANSON. Yes.

Senator MITCHELL. Among those 6, it is the only 1 and therefore the only 1 among the 50 States that did not have a PSRO in an adjoining State to come in and assist. The lack of baseline data, as I am sure you know, results from the fact that, not having a functioning PSRO and with the fiscal intermediary not having available data, it just isn't there, and they can't get it from the hospitals.

Mr. NATHANSON. We did, in fact, work with them. We have data available that they could use in doing their objectives. We worked with them on getting data sources. I am not exactly familiar with

the negotiations that went on on that, but we do have a 20-percent sample in all States that we have allowed the States to use where they didn't have PSRO baselines. They did not take advantage of that in a satisfactory way.

Senator MITCHELL. This hearing does not involve just one State, of course, and I won't take any more time on this, but I will accept the invitation implicit in your statement that you are not familiar with all the details, but acquaint you with them at a subsequent time. [Laughter.]

And see if we can't work it out in a satisfactory manner, because as you know, the proposal there has the support of not only all the medical groups but the fiscal intermediary as well, which does not want to have this task devolved upon itself. I would like to make one additional comment. All of this, of course, assumes the validity of the data upon which the objectives are based.

We will, I gather from the witness list, be hearing from people who disagree with that fundamental assumption on which the whole edifice is based and constructed. And I must say I commend the effort, and I think we have to do what we can, but I have some difficulty in accepting the premise that you can quantify to this precise a degree certain numbers that you are going to reduce from 173 to 130 the number of incidents in a certain prescribed area.

Mr. NATHANSON. As we said, Senator, we feel that, because of the requirement, we must negotiate performance-based contracts based on outcome objectives. We must have numbers as targets and starting points, and I think part of the problem is that when these numbers get written down on a page, they acquire a kind of a mystique that they shouldn't really have.

We have in several cases been willing to tell the PRO that where we feel and they feel the data is inadequate, we would be perfectly willing to recalibrate it. That is, if we have better data, if we find it in fact a problem as Dr. Davis said, if we find that there is a problem that isn't really a problem, or if they find some other problem that they think they should look at. So, I think a basic problem has been that we probably focused too much on the fact that there are numbers in these bids. There have to be, or we can't negotiate contracts.

Senator MITCHELL. The saving grace seems to be—Dr. Davis, your statement—and correct me if I am wrong—that these objectives are based upon problems identified by the local groups themselves and based upon studies which indicate in that instance that these are achievable objectives.

Dr. DAVIS. Yes, that is correct. And that is why we have said that if they go back and they feel that those studies are in some way flawed or don't produce the exact data that they had initially started with, we are perfectly willing to substitute or to agree that there is another issue or problem that they ought to look at rather than that. But it gives us something from which to start to measure productivity.

Mr. KAPPERT. There are two specific things we have done already. Where they have presented us objectives that we don't believe can be achieved, we have rejected them in some contracts. And beyond that, some contracts have provisions written in them now that say we are so uncertain about a particular objective that

we will revisit it in a particular length of time. So, we are not trying to get locked into unrealistic things that people just can't do.

Senator MITCHELL. I have other questions, but in the interests of time, and I know there are other witnesses who want to be heard, I thank you Dr. Davis, Mr. Nathanson, and Mr. Kappert. Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you, George. Let me make one observation. Thank you for bringing up the Maine situation. I have lived with some form of peer review for so long that I had forgotten that part of the country wasn't so-called blessed with it. [Laughter].

And I think it was most appropriate that you asked us to be particularly concerned about the medical care beneficiaries that live in those six States. So, I appreciate that. Now, if you are going to be able to stick around——

Dr. DAVIS. Yes, we will be.

Senator DURENBERGER. It would certainly be helpful if someone could let the Administrator and her associates sit somewhere up front.

I call Dr. Thomas Dehn, vice president of the American Medical Peer Review Association and chairman of the Private Sector Task Force on PRO Implementation, on behalf of the American Medical Peer Review Association, Washington, DC. And Dr. Harry S. Weeks, Jr., president of the West Virginia Medical Institute and chairman of the American Medical Peer Review Association's Legislative Affairs Committee, who is here on behalf of the West Virginia Medical Institute. And Andy Webber is with them. We appreciate your being here. Tom, this is your second trip. The bodies that you have pulled out of the haunts in Milwaukee are haunting the DRG system. Wherever I go in the country, and perhaps you can tell us that things look a little bit better today than they did back in February and share with us your reaction to the comments that we received from the Administrator.

DR. THOMAS DEHN, VICE PRESIDENT OF THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION AND CHAIRMAN OF THE PRIVATE SECTOR TASK FORCE ON PRO IMPLEMENTATION

Dr. DEHN. They certainly do look better, Senator, and thank you for the opportunity to appear before you and Senator Mitchell this afternoon. As indicated, I am Dr. Thomas Dehn, a practicing physician in the city of Milwaukee, WI, and vice president of the American Medical Peer Review Association. We have submitted some written testimony in conjunction with my oral statements, and I would like to have the opportunity to enter those into the record.

Senator DURENBERGER. Your written statement will, without objection, be made part of the record.

Dr. DEHN. As you pointed out, Senator, both of us have been liberally quoted since our previous meeting in February with regard to the prospective payment system, as well as PRO, and I would like to reiterate that I, as well as our organization, stand in support of the prospective payment system, and in specific support of the implementation of the PRO Program. So, despite some reports to the contrary, we are in support of the prospective payment system and feel that it is a reasonable approach to controlling ex-

cessive health care costs. I might mention to Senator Mitchell that a few of our member organizations would like to enlist you on their behalf to plead their case. [Laughter.]

Dr. DEHN. Consistent with your request, though, I had intended to confine my comments to three very brief statements. I may make a few additional comments with regard to some of the issues that you brought up earlier. The three primary points that I would like to discuss with you today is the concern that our organization has with regard to the prescriptive nature of the program, two the numerical objectives, and we believe that it is time to rethink our approach to the quality of care issues.

Senator MITCHELL. Excuse me. A vote is now in progress. That is why Senator Durenberger has to leave. I will stay here. You keep going. I will stay, and then when he returns I will leave and vote.

Dr. DEHN. Thank you, Senator Mitchell. The prescriptive nature of the program as alluded to earlier and a rebuttal attempted by members of the Health Care Financing Administration, I think, remains in evidence and it is something that we must discuss. Dr. Davis kindly mentioned and presented——

Senator DURENBERGER. Excuse me. This is going to shoot a small hole in my voting record, but this is more important. Could you tell?

Dr. DEHN. I will as my testimony goes on. Incidentally, I would like to compliment the Health Care Financing Administration. They have been most cooperative in our efforts to implement the program, as well as their efforts to implement the program, and though I will be critical of some of the items within the implementation period, overall we have been very pleased. And I may find myself even in the uncomfortable position of defending Health Care Financing Administration, which may not get me back to Milwaukee intact. [Laughter.]

I am glad you are back, Senator, because I had done my homework and dug out some information with regard to Painsville, Minnesota, a city that—no pun intended with regard to the name—but a city that both of us are familiar with. I would like to present the situation in Painsville, MI, to elucidate the problems with the prescriptive nature of the program denied by Dr. Davis.

Painsville, MI according to the information that I have available has about a 99-bed hospital and about 1,000 admissions a year. It is reasonable to assume that about half of those admissions are medicare admissions, and that means about 500. If we divided those into a quarterly review, as your Minnesota PRO would have to do, we would find that if a PRO were reviewing the experience in Painsville on a quarterly basis, and there were evidence of three—no more than three—inappropriate admissions the PRO and the hospital involved would be required to perform 100 percent admission review for the following quarter. I think that that is a waste of resources. For instance, we may very well, as a PRO, find that those three admissions were related to one physician. And it seems rather wasteful in terms of resources to concentrate 100 percent of admission review on the hospital in Painsville when we could perhaps focus it on one physician. The program is replete with evidence of this kind of a prescriptive approach to the legislation contrary to your intentions. I call your attention and the attention of

the staff to Dr. Davis' testimony on page 4. While her verbal testimony, implies flexibility in the program, her written testimony indicates the following: ". . . leaves to the bidder the responsibility to specify what particular utilization and quality issues will be addressed locally. Page 4, though apple pie, seems to be followed by page 5, page 6, page 7, and page 8, which are very prescriptive—is a very prescriptive document in terms of the methodology by which we are to conduct review. This outlines a mechanism that gives us very little wiggle room, and I think that as a PRO we need relief from some of this constrictive and relatively restrictive process oriented approach to reviewing medical care.

Senator DURENBERGER. How many pages do you have in your testimony that will point out to us the problems like the overbureaucratization of the trigger for the 100-percent admission?

Dr. DEHN. I would say about 4 or 5 pages. We are going kind of page-for-page here with them. [Laughter.]

The testimony offered earlier did not frankly address the mandated review plan which is the example that I gave you. In addition, the difficulties that some of us may have with the objectives—there is a concurrent requirement to perform mandated review activities. The 2½ percent that I alluded to in the Painsville hospital is an example. And those examples, I am sure you know, are fairly common throughout the country. Dr. Weeks will discuss that in a bit.

With regard to the numerical objectives, we appreciate the fact that Dr. Davis indicated that HCFA will be flexible. I think it is important to note that the PRO's that have signed contracts have assumed the responsibility for accepting the target goals—however, we want to describe them—to be achieved at the end of the 2 years. It is, however, important to note that the baseline data that Senator Mitchell alluded to earlier is baseline data that was developed and collected under a completely different reimbursement scheme, and so there may be holes in the data that we have, though it seems to be good data in terms of a cost-based reimbursement system. The conjectures that we made on the basis of that data may prove to be inappropriate in terms of a prospective reimbursement system. We appreciate both in Dr. Davis' written testimony as well as her verbal testimony assurances that we will have the opportunity, and I would appreciate the authority, to renegotiate these objectives if they seem to be irrelevant to the prospective payment system. I think this is all our best guess at this point. So, I would like the opportunity to have the authority perhaps to review these objectives and quotas, or however we want to describe them, within 6 or 7 months after the implementation of the program. I might add that as president of an HMO, I would not be so naive as to lock my staff into target goals for 2 years in this volatile medical marketplace. I think we need the flexibility to change these targets and these goals as appropriate.

Next, I think it is time that we asked Health Care Financing seriously to bite the bullet with regard to quality review. To say that their quality review program is weak, I think, is a compliment. It would seem to me that if you are going to implement a program as Congress has, that inverts the fiscal incentives in a health care delivery system, that a reasonable approach to quality review would

be to try and envision those potential breeches that would occur as a result of the fiscal incentives. For instance, short stays. If we assume that there will be some form of harassment to decrease admissions, we can also assume that physicians and other healt care officials may be doing more in their offices than they had been doing in the past. And I think it is important to work out some sort of screening criteria so that we could identify adverse impact of outpatient management. If the whole inversion of the fiscal incentives will be to provide more and more care outside of the acute care setting, then I think we can, with our intellect, develop a screening criteria that will identify breeches in care.

I think that at this critical juncture in the implementation of prospective payment, that is the kind of information that would be important to deliver to yours and our constituency and that is, "even though we had fiddled around with the payment mechanism, we don't think that it is compromising quality". And this is why. "And here is a list of criteria." Now, we have developed these criteria. They aren't new. The technology is available to implement screening criteria. It has been done in California. I believe the Hospital Corporation of America uses similar criteria. We presented these to Health Care Financing, and for some reason or another, they have rejected the concept. We would ask that Health Care Financing reopen the discussions with regard to quality review and perhaps, if appropriate, amend the contracts that have already been let.

I would like to make a few additional observations. And that is that in the HMO setting—and I have alluded to that before—but in the HMO setting, we have noticed that when we begin to constrict or provide disincentives for the use of acute care facilities, there is "in fact" increased use of office practice. Some appropriate and some perhaps inappropriate. It would seem important that we all consider at this time—since you have invited a kind of an open dialog today—that we consider the fact that perhaps Peer Review Organizations ought to be given the responsibility to review outpatient treatment modalities as well. I think it is a bubble that seems to be rising as we begin to press down on what are referred to in many cases as inappropriate hospital admissions. In a few minutes, you will hear from Mr. Jack Owen, speaking on behalf of the Hospital Association, and Mr. Owen will identify some questions and some concerns on the basis of the Hospital Association, some of which I agree with and some of which I don't. There is an important point, though, and that is that we really do have to establish a dialog with the Hospital Association and a cooperative approach to this. The power that the Hospital Association has to jam up this system is incredible, and if there is anything that we can do to alleviate that problem, I think we all would be well advised to do so. There were some points made with regard to quotas, and I think if I might speak for the moment in defense of Health Care Financing Administration. Very clearly, regarding the contract that we signed in the State of Wisconsin—if we were at the end of our 2 years, and we were to provide data to Health Care Financing Administration that there were more medicare admissions to the hospital than last year, we would not be in violation of the contract. It is important to note that the objectives that are negotiated are not

objectives that say—and I think this was a point that you were very concerned about, Senator——

Senator DURENBERGER. Yes, that is right.

Dr. DEHN. The objective does not say that there have to be less admissions overall. The objective says you tell us where inappropriate admissions are, and you tell us realistically how many of those inappropriate admissions you feel you can reduce. Now, I would have to—and I hope it doesn't sound facetious—say that when we tell the Hospital Association and other providers—that is PRO's—we will reduce inappropriate admissions by 25 percent, I think they ought to take the 75 percent of inappropriate admissions and run with it. We are not talking about stealing 25 percent of health care from our elderly. We are talking about reviewing inappropriate admissions and going on the hook, committing ourselves, in the best manner possible, to reducing those inappropriate admissions. I think the term "inappropriate" is the key word and the key operative word here. As I said earlier, our PRO contract will not be in noncompliance if overall rates of admission increase. We will be in noncompliance if we don't deliver on the objectives to which we agreed. And we think that, with some modifications, our objectives were reasonable. There was a kind of an obnoxious negotiating process which we think could be streamlined a bit, but nonetheless, we did sign the contract and we will be held accountable for it.

With regard to avoidable deaths, it is an extremely inflammatory term. There are probably avoidable deaths in hospitals. The way we approach that in Wisconsin—and I think we need examples here—we took a look at how best to get at that particular question, and I think that each PRO will have a different approach to how to identify whether there are in fact avoidable deaths or whether there are not. So, we tried to get our best minds together, and we closed ourselves in a room, and we said, you know, if an elderly citizen gets admitted to a hospital for an elective surgical procedure, he probably shouldn't die. And if the elective surgical procedure—technically called a class I, which is usually a minimal procedure—revision of the hand or something like that—if the elective surgical procedure is a class I, they really ought not to die. So, we took a look at how many elective admissions for surgical procedures in class I resulted in deaths in the State of Wisconsin and we found about 1,300. I may be a little off on the numbers. We said, that's a lot, and so we took a look at the computer run and where that happened. I mean, why did they die? Let me say, with that process, we are not accurate in terms of adequately defining the patient population. So, when we took a look at that 1,300, we said, now, wait a minute. There are some people with underlying cancers who electively come in perhaps to have a catheter inserted for chemotherapy or something like that. And those are class I procedures—elective admissions—and those people may die. So, let's eliminate all of those. And we went through, and I will tell you, we gave every benefit of the doubt to all of the providers. And we said there are about 250 we can't explain. Now, I am not sure that those are avoidable deaths, but you can bet they got our attention.

And we think that we can reduce that 200—we don't know how much—but we have gone on the hook for a given percentage, and we think it is a reasonable percentage, especially in those terms. It

is an inflammatory, wild objective. but you know, it is not bad to quantitate. It is one of the few quality objectives that HCFA has asked us to take a look that actually lends itself to quantification. The rest of them don't, and I think that the approach that we should take in the other areas should include quantification of screening criteria with regard to quality that will identify breeches in quality of care. That is about the best I can do, and I would like to offer also to stay through the entire proceedings if you have any additional questions with regard to this, and I would like to answer any questions you might have.

Senator DURENBERGER. All right. You are welcome to do that, and I appreciate the comments. Dr. Weeks.

[Dr. Dehn's prepared written statement follows:]

STATEMENT OF THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH
SENATE COMMITTEE ON FINANCE
ON IMPLEMENTATION OF THE PRO PROGRAM

JULY 31, 1984

Presented by: Thomas G. Dehn, M.D.
Vice President, AMPRA

EXECUTIVE SUMMARY

1. The American Medical Peer Review Association (AMPRA) is now satisfied that the Administration is making a concerted effort to implement the Peer Review Organization (PRO) program. AMPRA wishes to publicly thank the Subcommittee for its continued oversight of the implementation process and for its assistance in the enactment of recent amendments to the Federal Deficit Reduction Act of 1984. These amendments will ease the difficult transition from PSRO to PRO and assure continuation of Medicare review by physician based organizations.

2. AMPRA is concerned that the required review plan under Medicare Prospective Payment (PPS) is needlessly proscriptive, unnecessarily burdensome to provider institutions, and often concentrates PRO staff energies on activities that do not yield tangible results. This proscriptive approach is seriously at odds with the philosophy of the Durenberger PRO law that calls for the negotiation of performance based contracts, allowing PROs the flexibility to reach desired outcomes by whatever means appropriate. At the very least, AMPRA recommends that PROs be allowed to eliminate mandated review activities, where evidence can be provided to the Health Care Financing Administration (HCFA) that the review process is not uncovering patterns of inappropriate hospital behavior. Movement away from mandated review activities would greatly enhance the cost effectiveness of PRO review.

3. AMPRA applauds the incentives created by performance based PRO contracts and accepts the need for the HCFA to quantify objectives for purposes of holding PROs accountable and measuring PRO performance. However, Congress must be forewarned and HCFA must acknowledge that the setting of numerical objectives, particularly in the quality of care area, is an imperfect science. Baseline data, that establishes the existence of inappropriate admissions and quality of care problems, is not reliable and has been extrapolated from that period of time before the introduction of PPS, calling into question its present relevance. AMPRA recommends that, in recognition of the complexity of the objective setting process, PROs be permitted the flexibility to renegotiate objectives during the course of the contract period, in order to redirect efforts on verifiable problem areas. In addition, contract language should be added which identifies numerical objectives as approximate targets rather than absolute contractual obligations. AMPRA wishes to assure all Medicare beneficiaries and hospitals that under no circumstances will PROs base review decisions on the need to meet negotiated outcomes.

4. AMPRA believes the quality assurance program outlined in PRO contracts is too restrictive and limited and lacks the innovation needed at a time when constrained resources greatly enhance the potential for compromises in quality. AMPRA, therefore, recommends the application of generic patient outcome criteria to assist in the identification of quality problems under PPS. This approach would yield a more appropriate basis by which to establish quantitative quality objectives with an empirical basis.

5. AMPRA insists that HCFA state at the onset of the program the evaluation criteria that will be applied to measure PRO performance. This must include the dollar savings to be credited to PROs for reductions in inappropriate hospital utilization, the cost/benefit expectations for PROs by HCFA, and a clear enunciation of the assumed impact of prospective payment on hospital admissions such that PRO impact can be isolated.

6. Fiscal constraints on inpatient services created by the prospective payment system will encourage the "unbundling" of hospital services. AMPRA recommends that PROs be given responsibility to review services for Medicare in the ambulatory setting.

Mr. Chairman, I am Thomas Dehn, M.D., Vice President of the American Medical Peer Review Association (AMPRA) and a practicing physician in Milwaukee, Wisconsin. In addition, I recently chaired the private sector task force on implementation of the PRO program, convened by AMPRA, and including representatives from business, insurance, consumers, hospitals, state government and others interested in and supportive of this vital program. With me is Andrew Webber, Executive Vice President of AMPRA. On behalf of AMPRA and its member Professional Standard Review Organizations (PSROs) and Peer Review Organizations (PROs) I want to express our sincere appreciation for the opportunity to share our views with you and other members of the Subcommittee.

Mr. Chairman, we are pleased that you and the Subcommittee are continuing to take a very active interest in the implementation of the PRO program. We believe your hearing last January was, in large measure, responsible for the remarkable progress achieved since that time. Overall, we have been satisfied with the efforts of the Health Care Financing Administration (HCFA) with respect to the development of program regulations and their willingness to keep AMPRA and its members informed of emerging issues. We applaud the fact that, to date, PRO contracts have been signed in 25 states. We are convinced now that the Administration is committed to the implementation of the PRO program.

We would also like to express our appreciation for your help in the enactment of several critical statutory amendments which provide stability in program funding during this transition and permit broader representation of health provider and purchaser interests on PRO boards. We feel strongly that PRO governing boards should be a forum where medical review policy issues can be addressed by a cross section of community interests including patients, providers, and purchaser of services.

Now that the implementation of the PRO program is moving forward and an orderly transition from PSRO to PRO has been assured, it is appropriate that the Subcommittee has called interested parties together to discuss fundamental issues surrou[illegible] the nature and scope of the PRO program. The challenge before us is to translate the conceptual framework of the "Peer Review Improvement Act" into an administratively rational and cost effective review program, all with the understanding that this new review system must be tailored to the incentives created by Medicare prospective payment (PPS).

AMPRA recognizes the complexity of this task at hand and wishes to acknowledge the great efforts put forward by HCFA staff. We come before the Subcommittee today not as an adversary but as a working and willing partner with the federal government, physician community, hospital industry and purchasers of health care, in building an innovative new review program. Our ability to work together over this next critical period will set the tone for the future and may well determine the success or failure of the PRO program.

In this spirit of cooperation and with the knowledge gleaned from a decade of peer review experience, AMPRA wishes to share its views and recommendations with the Subcommittee on the evolving PRO program. Our concerns focus on the following issues: the proscriptive nature of the required review plan under PPS; the difficulty of setting absolute numerical objectives for performance based PRO contracts; the need for an innovative approach and a real commitment to quality of care review, including basic research to refine definitions and the measurement of quality; a clearer enunciation by HCFA of the evaluation criteria to be applied in measuring PRO performance; and the growing need for ambulatory review as incentives in the medical care system drive services from the inpatient setting.

PPS Required Review Plan

Mr. Chairman, one of the primary criticisms of the Professional Standard Review Organizations (PSROs) was its proscriptive and regulatory nature. A basic presumption plagued the program from the start: that a uniform review process, mandated from Washington and applied across all hospitals is the appropriate way to structure a national medical review system. An entire shelf of the AMPRA library is filled with PSRO transmittals, issued from HCFA Central office, symbolizing to me this failure to recognize variations in hospital utilization to speak nothing of variations in pricing, capacity, management, staffing and a host of other characteristics. No set review formula could ever hope to effectively address such diversity in hospital and physician performance; and no set formula from Washington could ever begin to substitute for and incorporate the knowledge and expertise of the physicians and staff of peer review organizations working inside their own communities.

It was in recognition of just these points, Mr. Chairman, that AMPRA worked so diligently with you and your colleagues on restructuring an approach to Medicare review that is flexible and establishes program accountability through the negotiation of performance based contracts. Unfortunately, as we expressed to the Subcommittee back in January at the first of the PRO implementation hearings, AMPRA believes that there has been a migration back in the direction of a very proscriptive set of instructions which will stifle innovation, unnecessarily burden provider institutions, and concentrate PRO staff energies on activities that do not yield the greatest results. This approach, spelled out in excruciating detail in PSRO Transmittal 107 and attached to every PRO agreement as a contractual obligation, represents much that was wrong with PSRO and is seriously at odds with the PRO program philosophy.

While time does not permit a careful review of each instruction for the required review plan, a partial listing of the review activities is illustrative of the extent to which the PRO work agenda continues to be mandated from Washington: preadmission review of 5 procedure related DRGs; retrospective admission review of every 20th Medicare claim; review of admissions occurring within 7 days of discharge; review of a random sample of cases for validation of diagnostic and procedural coding for DRG grouping; review of every DRG 468; review of every permanent cardiac pacemaker implantation; review of every transfer from a PPS hospital to any other acute hospital; review of every cost outlier; review of every day outlier. In addition, in those areas in which PROs are performing review of samples, PROs are triggered up to a higher volume of review when "patterns" of unnecessary utilization, as defined by HCFA, are uncovered.

AMPRA wishes to make clear that its objections to the PRO required review plan does not center on the topic areas for review, indeed most are appropriate given the incentives under PPS. AMPRA's concern is with the proscriptive approach to review that burdens good hospital performers with unnecessary monitoring and does not give PRO physicians and staff the flexibility to concentrate activities on identified problem areas or institutions. The rigidity of this process oriented approach is not in the end, the most effective means of review. To be consistent with the legislative intent of the new PRO law, HCFA must begin to move away from the required review plan and the mentality that a single, uniform approach can begin to address the different quality of care and utilization problems evidenced in the acute care setting. Already, many of the review plan categories, like admission and readmissions, overlap with the objectives negotiated in the PRO contracts and should be

discarded. At the very least, PROs should be allowed to eliminate required review activities when PROs can provide documentation that the review process is not uncovering patterns of inappropriate hospital behavior. It is time to reward the good performers, and target PRO energies where the payoff is greatest.

Performance Based Contracts

At the beginning of our discussion of objective setting in performance based contracts, AMPRA wishes to applaud the incentives created by this innovative approach and predicts that it will result in cost effective review by peer review organizations. This is particularly true if a flexible approach to the PRO required review plan is adopted by HCFA as suggested above. AMPRA also accepts the need for HCFA to quantify objectives for purposes of program accountability and as a tool to measure PRO performance. However, acceptance of the principle of performance based contracting for medical review services, does not make the task of quantifying objectives in the utilization and quality areas an easy one. It is this concern that AMPRA brings before you today.

Growing out of our experience with the PSRO program and hospital utilization review programs, we know that quality medical care is cost-effective care. But, we have also learned that medical review is not an exact science. There are still many judgmental aspects in the analysis of patterns of utilization and in the design of appropriate diagnostic tools. Thus, the capacity to anticipate the types of cases which may be experienced over time is limited. The factors that determine the utilization of hospital services and that affect the outcome of treatment regimens have not been fully quantified and are not likely to be capable of absolute quantification in the forseeable future.

While we understand HCFA's intent and agree that contractor accountability is essential, we believe that the uniform reliance on numerical objectives as the primary indicator of PRO performance--particularly at this early stage of program development--is unrealistic and fails to recognize the imperfect nature of the medical review process. Let me illustrate what I am referring to by describing briefly the objective-setting process in the contract negotiations. Essentially, PROs are required to establish numerical goals for the utilization of inpatient hospital services in their area and numerical quality objectives. Examples of utilization goals include:

- o reductions in the overall admission rate by Medicare beneficiaries;
- o reductions in the rate of hospital admissions for cases which can be treated on an outpatient basis; and,
- o reductions in appropriate admissions and invasive procedures by specific DRG's.

Quality-of-care objectives that have been made a part of PRO contracts include:

- o reductions in incidents of unnecessary surgery;
- o reductions in unnecessary hospital readmissions resulting from sub-standard care in a previous admission; and,
- o reductions in avoidable deaths.

AMPRA believes there are many problems associated with the prospective establishment of numerical targets for both utilization and quality objectives. In the case of utilization, there is no definitive methodology to assess the appropriateness of admissions absent a retrospective review of each and every medical record. Even here, the lack of medical consensus on the appropriateness of treatment for certain procedures complicates this effort. Norms and standards for per capita admission rates have not been established for given inpatient procedures, much less widely reported, with the exception

of the pioneering work done by Professor Jack Wennberg of Dartmouth College. Basing admission objectives for individual states on their position relative to national admission rates for Medicare beneficiaries; as HCFA appears to have done in the negotiating process with PROs, does not consider the various demographic, environmental, and resource allocation characteristics that influence Medicare rates of admissions.

AMPRA is ready to accept utilization objectives that work in the direction of reduced admissions; this is an appropriate goal given medical review experience, literature in the field, and the variations in admission patterns among hospitals. AMPRA's concern is focused on HCFA's assumption that these admission objectives can be established with certainty and are based on medically sound empirical evidence.

As difficult as it is to set admission objectives, the task pales in comparison to the problems encountered in setting numerically based quality objectives. To our knowledge, there is very little empirical data on the outcomes of patients with similar diagnoses who are treated with different therapeutic approaches. To cite an example receiving wide attention, recent findings on effective treatment of coronary artery disease suggest a changing medical consensus. The outcome data derived from a number of critical studies that followed patients for five or more years suggests that, on average, medically treated patients do as well as those who had by-pass surgery. This happens to be a disease which has been the focus of extensive medical research. Even here, however, conclusive evidence concerning the most effective treatment is still lacking. In most other areas, we simply do no have enough information to determine with precision which therapeutic approaches are the "right ones" for all patients.

An additional problem mars a PRO's ability to establish quality objectives. Baseline data, needed to validate the existence of quality problems, was extrapolated from the time period before the introduction of PPS, calling into question its present relevance. The incentives under PPS have created new quality of care concerns only now beginning to be recognized as the PPS system is introduced and gains momentum.

AMPRA does not wish to shirk the responsibility of quantifying objectives in performance based PRO contracts. Our plea is that the difficulty of the process be fully recognized; and our recommendation is that flexibility be written into the negotiated agreements. In specific terms, AMPRA must insist that latitude be afforded PRO contractors, who wish to renegotiate contracts in response to new evidence of verifiable problems. This approach will help assure that PRO energies are cost effectively targetted and not misdirected because of an inability to prospectively identify utilization and quality problems. In addition, AMPRA recommends that contract language be added which clarifies that numerical objectives are appropriate targets rather than contractual obligations. Speaking for all PROs, AMPRA wishes to make clear to Medicare beneficiaries and hospitals that under no circumstances will PROs base review decisions on the need the meet negotiated outcomes. We will continue to base our decisions on our best professional judgement regardless of the consequences on the maintenance or extension of the PRO's contract with HCFA.

Quality of Care Review

Two decades ago, when Congress debated the establishment of the Medicaid and Medicare programs, the primary theme driving health care policy decisions was the need to improve access to, and the quality of, medical care for all Americans. Twenty years later, with the revolutionary enactment of PPS, the

theme is cost management. Today, the medical care system must struggle to compete for limited societal resources. Efficiency, measured in terms of the provision of medical care services at low cost, will be handsomely rewarded in this present era. The fear, of course, is that the efficacy of medical intervention, measured in terms of maximizing quality health outcomes for individual patients, will be adversely impacted. There is no greater challenge to the medical care system than the maintenance of quality of care in this era of limited resources. The challenge becomes even more critical in the knowledge that if quality and access again become the primary themes in the Washington health care policy debate, we will not have the societal resources at hand that we did two decades ago to address the problem.

It is imperative, therefore, that we commit ourselves now to a renewed effort to build a systematic approach to the definition, measurement and maintenance of quality of care before compromises in quality become a widespread concern. AMPRA wishes to acknowledge, even after ten years of medical review experience, how nascent a science quality of care review remains. We come before Congress to plea for a concerted research effort into the development of quality of care measurements. This effort should include the development of health outcome criteria; the refinement and application of severity of illness indices such that patient severity levels can be monitored throughout the treatment episode; and longitudinal studies of patient outcomes, particularly for surgical procedures that evidence high treatment variation. Such variation is usually an indicator of an absence in medical consensus.

As a partner in this commitment to quality assurance, PROs must take a lead role in applying innovative new approaches across broad patient populations. The quality assurance program outlined by HCFA in the PRO

program, AMPRA believes, is too restrictive and limited. As noted before, the establishment of quantified quality objectives is problematic in the absence of reliable baseline data. AMPRA must also record its discomfort with the topic areas HCFA selected for quality objectives. In particular, "the reduce avoidable death" category, while certainly a laudable outcome, is politically volatile with its inherent presumption of widespread negligence, has serious medical liability implications, and is absent reliable baseline data.

AMPRA recommends as a methodology to build a more appropriate foundation for the establishment of quality of care objectives, the application of outcome criteria which can help identify potential cases of poor quality. What we can do--if given sufficient time--is to develop patient outcome indicators which serve as the basis for a screening program as we have previously recommended to HCFA. The criteria included in a PRO screening program should be generic--that is, applicable to a broad range of medical services. In the report of the private sector task force on PRO implementation, which AMPRA convened, we included several examples of the criteria appropriate to the identification of potential compromises in quality medical care. They included: admissions for adverse results in outpatient department services; readmissions due to complications from a previous hospitalization; cardiac or respiratory arrest.

By using these screening criteria, it is possible to identify those cases which have a higher potential for compromises in the quality of care. Of course, any quality review program must then examine the underlying medical record of cases identified by screening to determine whether there was any breach of acceptable quality patterns. It is not possible to predict in advance the number of quality compromises that will be found. Mr. Chairman, AMPRA believes that this approach based on screening criteria, retrospective

review of medical records and documentation of a reduction in such incidents over a based period is a more effective and reasonable approach to quality assurance. This process builds a baseline of verifiable quality concerns which could lead to the most appropriate establishment of quantitative objectives with an empirical basis.

PRO Evaluation Criteria

Mr. Chairman, I would now like to turn your attention to a particularly sensitive issue to the AMPRA membership: the evaluation criteria that will be applied by HCFA to measure PRO performance. This concern finds its genesis in the experience of the PSRO program, in which PSROs were unfairly held responsible for factors over which they had no control. We remember with lingering bitterness the published evaluations that judged our performance on our ability to control total Medicare expenditures. In the height of absurdity, we were even held responsible in one PSRO oversight hearing by one outspoken congressional critique for the shifting of costs to the private sector.

A simple equation must be remembered in judging the performance of all medical review entities: total cost = unit price x unit volume. PROs, like PSROs before them, do not have the ability to influence the price side of the total cost equation. When hospital administrators responded to decreasing lengths of stay caused by PSRO review by increasing charges to the federal government, PSROs were powerless to intervene. Additionally, PROs and PSROs do not have the ability to influence the frequency and appropriateness of services that they are not reviewing. Hence, PSROs should not have been responsible for the appropriateness of Medicare admissions when they were only instructed to review Medicare length of stay and ancillary services; correspondingly, PROs

should not be held responsible for the shifting of Medicare services to the outpatient setting and to the private sector, as closer scrutiny of Medicare admissions by PROs causes the ballooning of services somewhere else in the medical care system.

With this historical perspective as our guide, AMPRA must insist that HCFA enunciate their working hypotheses governing the development of PRO evaluation criteria. HCFA must state, at the onset of the program, utilization behavior that HCFA assumes should be influenced by PRO intervention. At the very least, HCFA must state its hypothesis regarding the impact of prospective payment on hospital admissions, such that PRO impact can be isolated and measurable. It is AMPRA's working hypothesis that the fiscal incentives of PPS will increase Medicare admission rates. If this does reflect the working hypothesis for HCFA, we need, at the beginning of the contract period, to debate the issue.

Our uncertainty about PRO evaluation criteria is fueled, in large part, by the lack of consistency we have observed in the negotiated objectives in the 25 PRO contracts signed to date. For example, in some contracts, there are overall targets for reductions in Medicare admissions while in other contracts there are only targets for specific diagnostic categories. Thus, we are in doubt as to whether HCFA has established an overall admissions goal for every PRO, and more importantly, how HCFA will evaluate the accomplishment of overall targets but fail in one or more specific utilization goals or vice versa. The absence of a specific evaluation methodology creates a great deal of anxiety and may result in misapplication of PRO resources.

In addition to the above concerns, AMPRA asks HCFA to come forward with their expectations regarding the cost to benefit ratio that PRO performance is anticipated to yield. We insist that these expectations, if there are any, not be applied uniformly across all PROs. HCFA must acknowledge that maintenance of existing patterns of appropriate hospital behavior is as much a worthy goal as reductions in inappropriate care. Yet it is difficult to measure this PRO performance objective in quantifiable terms.

Finally, HCFA, at the very least, must pronounce the dollar savings to be credited to PROs for reductions in inappropriate hospital admissions. This must be calculated with some recognition of the "favorable presumption" rule that triggers hospital payment even when inappropriate utilization has been identified.

PRO Review in the Outpatient Setting

The final issue we want to address is the need to begin planning for an expansion of PRO review to include the utilization of non-acute facilities and the growing volume of services provided in an ambulatory setting. As you know, the new economic incentives for hospitals under prospective payment could lead to inappropriate use of these other service settings. At the same time, pressure on the prices of services by public and private purchasers is stimulating the growth of free-standing health service sites. Many of the services provided by these organizations were traditionally provided by hospitals. While market forces can be effective constraints on hospital cost increases, we certainly want to avoid the proliferation of unnecessary delivery organizations which stimulate more demand and raise expenditures for health care in the aggregate.

PROs can be tools for measuring the appropriate use of services outside the inpatient setting. We believe PRO's should be encouraged over time to invest in the development of standards and criteria for the assessment of quality in these settings and in methodologies for evaluating adherence to acceptable practice patterns outside of acute care institutions. We urge HCFA to consider PRO review responsibility in the outpatient setting.

Mr. Chairman, again we want to express our appreciation for the opportunity to present our views and recommendations and for your continuing support for physician-based medical review. We have sought to provide constructive assistance to HCFA during this transitional period, and we expect to continue working toward the establishment of a strong and effective PRO program.

STATEMENT OF DR. HARRY S. WEEKS, JR., PRESIDENT OF THE WEST VIRGINIA MEDICAL INSTITUTE AND CHAIRMAN OF THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION'S LEGISLATIVE AFFAIRS COMMITTEE

Dr. WEEKS. Thank you, Mr. Chairman. I would like to thank you and the subcommittee for this opportunity to appear. As medical director of the West Virginia Medical Institute, we can share with you our experience with PPS and the PRO program, recognizing that any experience at this point is brief. In the recent PRO contract award, I had the staff responsibility for supervising writing of the quality objectives and was a party to the contract negotiations.

I have submitted a written statement, and I would request that it be entered into the record.

Senator DURENBERGER. It will be made part of the record.

Dr. WEEKS. In my testimony, I have tried to point out some of the pluses and minuses of the objectives that we are talking about and of the mandated review elements and admission objectives. Aside from nitpicking the numbers, we cannot generate negative criticims. To the contrary, given the nature of PPS and the potential for problems, I would say that HCFA is doing something right. In considering the mandated elements, we find the most cost effective to be DRG validations. The best means for determining undertreatment or premature discharge, as well as manipulation of the system, is a review of readmissions within 7 days. Much to our surprise, the least productive in terms of dollars spent is review of cost of outliers. Partial information from fourth quarter 1983 and first quarter 1984 with charges totaling $5 million plus, less than $10,000 was denied and more than that figure was spent on review staff time. Since most of these charts are 4 to 6 inches thick, the detailed review required is quite time-consuming. There is always the possibility that significant reductions will occur in this review category, but our early impression is that this element should be watched for its cost effectiveness. I am not saying we should do away with it because you can hit a big payoff in some of these cases, but most of the ones we have looked at have been seriously ill patients who have been receiving proper care and they are just in there for long periods of time, and you find very little of anything that you can deny.

Of the quality objectives, as Tom has mentioned, the most onerous was the one concerning avoidable deaths. Definition, data, how to deal with the subject in a public document, how to avoid future legal problems, and how to come up with adequate numbers will continue to be serious considerations. Having previously been cited in West Virginia as having too few deaths, we had difficulty in writing an acceptable answer to this one. The objective on reducing complications will be difficult to meet and will require heavy interaction with the hospital quality assurance committees. The negotiation process can best be described as a limited one. We were pleased that someone actually read our proposal and surprised at the vast amount of detail, which included all our strengths and weaknesses that the HCFA review team had compiled. Although we had the whole document to consider, we did not know at the time of negotiations which areas would be targeted for discussion.

And we were asked at the time to fix hard numbers to categories for the medicare population when our only frame of reference was the total population. For instance, some endoscopic procedures can literally be performed on anyone under the age of 50, but in the 65-plus age group we are dealing with increased risk factors that make projections more difficult. In the give-and-take of negotiations, we were left with the impression that modifications to the objectives might be considered if historical data merited such. So, we would make a plea, too, for some degree of consideration in meeting the fixed numbers and the quality objective. Dr. Dehn has mentioned the 2.5-percent, or three-case level. We are getting a number of complaints from hospitals relevant to this, and it is not only the small rural hospitals but it is big and small. I think what we are saying, at least, is that in those hospitals that are making a sincere attempt to adhere to admission pattern monitoring and meeting some of the other objectives, that we are seeing one group that is very close or under the 2.5-percent level and another group that is really bad. And yet we have seen some hospitals that will drop from the 18-percent or 11-percent denial rate down to, let's say, 3.1 or 2.8 that we would not like to hit too hard because they are making a serious effort to comply and in the next quarter will probably come into line. But we have recommended, I think, either 17 or 19 hospitals removal of favorable waiver status. We would ask for some leniency in this 2.5-percent figure, perhaps up to but not exceeding 5 percent. Because when the 2.5-percent figure started, to the best of my knowledge, it started with medicare and we are only looking at sort of continued stay review and coverage issues and so forth on a 2-percent sample. Now, we are up in the 45- to 50-percent sample with a whole different set of objectives, and we are looking at things in a much different light. And about half of the admission denials are being given because of the inappropriateness of the setting. So, it is not truly a clean shot that we are taking at the hospitals.

Another source of confusion here is the scorekeeping. If you have a conscientious hospital, they try to keep track of this themselves. And we used to speak of these denials in terms of date of admission or date of discharge, and now it is the date of review. So, we run into this scorekeeping problem in our daily conversations with the hospital of, let's say, receiving charts from as far back—and hospitals will hold charts back, believe me—and submit them, let's say, in the second quarter from the first quarter. We do the review in the second quarter and then we are going to hold the reconsideration in the third quarter. And if you do reverse some of these, and we are at the present time reversing about 20 percent—some people are reporting as high as 50 percent—the hospitals want to match up the reconsideration with the denial and say, look, we would really look pretty good in this quarter, but we get into this conflict of times and how to count and what is really the effective date of the loss of favorable waiver status. So, we are into this particular discussion. I think 6 months down the line it will be minimized somewhat when we get all the flow of the numbers straightened out, but at the present time we, too, are hearing considerable—well, rhubarb might be a nice way of saying it—but we are

getting some heat from the hospitals because of the simple nature of the problem.

And we are also being flooded with requests because the hospitals know that this is the one appeal that they have in some instances, and it is also the first step in the appeal process, and others. We have also received a number of complaints from the hospitals about the overall cost relevant to review denials and so forth, and they are complaining bitterly about the cost of reproducing charts. And I have actually seen charts that were bigger than the DRG reimbursement rate in terms of number of pages, and I can sympathize with them a little bit—not too much—since they seem to target this one. But I mention it simply to bring out the fact that we are in the process of negotiating MOU's with hospitals. This seems to be one item that comes up frequently as something that ought to be negotiated into the MOU when, in fact, it is supposed to be built into the DRG rate. I have also left with your staff a number of questions that we are receiving from the hospitals relevant to the process and sort of a prelude to the negotiations, and to give you some idea of what the hospitals' concerns are.

They are trying to answer these in a uniform fashion. Part of this list reflects lack of knowledge of the law, or lack of knowledge of the process, and I can say we have a big PR and education effort out there ahead of us. The term flexibility and loss of flexibility has been bandied about here quite a bit today. I would like to join in. I think we did lose flexibility in the quality objectives in this particular contract. I think that it was probably an overreaction to AMA criticism when at one point it looked like there would be one or two mandated quality objectives, and we ended up with five. We lost some flexibility on the topic selection, but to me, I think we stand to lose something that is more important, and that is the loss of etiquette during peer review. I have rarely had a physician gripe at me if the decision is legitimate peer review, but the manner in which I tell him and the reason that I tell him are very, very important. And I would hate to have to do peer review for the wrong reason—the wrong reason being that I am trying to meet a hard fixed number in some of these objectives.

So, with that, I would like to conclude, Mr. Chairman, and stand ready for any questions.

[Dr. Weeks' prepared written statement follows:]

STATEMENT OF HARRY S. WEEKS, JR., M.D.

WEST VIRGINIA MEDICAL INSTITUTE

BEFORE THE

SUBCOMMITTEE ON HEALTH

SENATE FINANCE COMMITTEE

JULY 31, 1984

Mr. Chairman, I would like to thank you and the Subcommittee for this opportunity to appear before you today to discuss our impressions of the implementation of the PRO program. As Medical Director of the West Virginia Medical Institute, we can share with you our experience with PPS and the PRO program recognizing that our experience is brief. In the recent PRO contract award, I had staff responsibility for supervising writing of the quality objectives and was a party to the contract negotiations.

To gain the proper prospective for this discussion, we should recognize that there have been other forces at play which are being voiced as concerns about the PRO program. We see anxieties and attitudes in the publics we interface with - patients, physicians, hospital administrators and trustees - which are the result of heavy publicity about health care costs, massive hospital initiated education efforts on DRGs and the prospective payment mechanism and a generally accepted notion that the federal government appears to be getting out of the health care business. For the most part all parties are looking at recent changes cautiously with measured concern, but now and then we are experiencing open hostility with attendant actions.

In West Virginia, we have 68 acute care hospitals for which we perform medical review. We started PPS review in 21 hospitals on October 1, 1983 and another 21 on January 1, 1984. This experience plus experience gained from Admission Pattern Monitoring gave us insight into the PRO program. We were also fortunate enough to have a statewide PSRO program in place. In a sense, we were not typical of a number of statewide organizations vying for the PRO contract, but I can assure you we suffered the same stresses during the contracting process.

The primary impact of PPS in West Virginia has been a reduction in length of stay. Since October 1983, the total Title XVIII hospital population shows a reduction of 1.0 day. In the PPS hospitals this is approaching 1.5 days. The total admissions reflect no significant change through March 31, 1984. The hospital occupancy rates are down as a result of the decreased LOS. In the hospitals where level II APM (100% review) is occuring there is an apparent decrease in admissions. It is too early to make a definitive statement on this aspect of review since hospitals can delay bill submissions and give a false impression for a given quarter. In general, Admission Pattern Monitoring seems to be working well as a mechanism for identifying abnormal admission patterns and as an aggressive intervention tool in dealing with identified problems. Since the potential exists under APM of ending up with 100% of review on all admissions, budgeting and staffing for APM is a bit of a nightmare at times. In practice, we see hospitals that were focused down under PSRO because of their excellent utilization review programs having no difficulty with APM.

When we first read the RFP for the PRO program our initial reaction was negative in light of our knowledge of the PRO legistion. My personal reaction was disgust since the hoped for flexibility was missing and the numbers required to meet the various objectives would be very difficult to meet in a patient population of chronically ill individuals. We generally agreed with others who said it was too proscriptive. The time constraints and lack of data did not allow for much innovation so we settled down and put forth our best effort. We recognized the overlaps among the mandated review elements, utilization objectives and quality objectives and agreed that ultimately these overlaps would work in our favor if we could determine how we would be assessed in these areas.

Of the mandated review elements and utilization objectives we cannot generate negative criticism. To the contrary, given the nature of PPS and the potential for problems I would say that HCFA is doing something right. The most cost effective is DRG validation. The best for determining undertreatment or premature discharge as well as manipulation of the system is review of readmissions within seven days. Much to our surprise the least productive in terms of dollars spent is review of cost outliers. Partial information from 4Q83 and 1Q84 on charts with charges totaling $5,000,000 less than $10,000 was denied and more than that figure was spent on review staff time. Since these charts are 4-6 inches thick the detailed review required is quite time consuming. There is always the possibility that significant reductions will occur in this review category, but our early impression is that this element should be watched for its cost effectiveness.

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Of the quality objectives, the most onerous was the one concerning avoidable deaths. Definition, data, how to deal with the subject in a public document, how to avoid future legal problems and how to come up with adequate numbers were and will be serious considerations. Having been previously cited as having too few deaths we had difficulty in writing an acceptable answer. The objective on reducing complications will be difficult to meet and will require heavy interaction with hospital Quality Assurance Committees.

The negotiating process can best be described as a limited one. We were pleased that someone actually read our proposal and surprised at the vast amount of detail which included our strengths and weaknesses that the HCFA review team had compiled. Although we had the whole document to consider, we did not know those areas that were targeted for discussion during the negotiations. We were asked to fix hard numbers to categories for the Medicare population when our only frame of reference was the total population. Some endoscopic procedures can literally be performed on anyone under 50 years on an outpatient basis, but in the 65+ age group we are dealing with increased risk factors that make projections more difficult. In the give and take of negotiating we were left with the impression that modification to some objectives might be considered if historical data merited such. We make a plea for some degree of consideration in meeting the fixed numbers particularly in the quality objectives.

What problems do we foresee with the PRO program? Aside from the above noted concerns on objectives and negotiating we consider

two areas to be volatile in budgeting and staffing. These are Level II APM and reconsideration of denials. Our denial rate is now approximately 7% of cases reviewed. This rate increase has occurred because of tighter review - increased percentage of cases and change in criteria. The number of requests for reconsiderations has increased almost 100% over 1Q83. This number should drop after the first 6 months, but admission denials now translate into significant dollar losses for hospitals and we anticipate a heavy volume load based on the fact that this is the first step in the appeal process.

Hospital reaction to the PRO program indicates resistance in the presuable future. Recent statutory changes allowing hospital representation on PRO boards should improve communication and relations. There has been consistent questioning about the 2.5% or 3 cases level for loss of favorable waiver status. Since 1 denial in 40 cases reviewed can result in punitive action for a given quarter. There are many sides to the arguments about this figure and perhaps consideration should be given to increase this to no more than 5%. In practice, it may become a moot point if rebuttal on a case by case basis occurs. There is concern about sanctioning of physicians who are heavy admitters and we can foresee PRO activity increasing here. A constant complaint is about the cost of reproducing charts for review. Budgeting does not allow for 100% on site review and the cost of reproduction is supposedly built into DRG reimbursement, but this will be a contested point in negotiating MOUs with hospitals. A myriad of minor questions are being received which should be clarified within 90 days as information

on the program is disseminated. The real concern of course is loss of income to hospitals. As the hospitals adjust to PPS this should be less of a problem. At the present, there are employee layoffs and conjecture about hospital closures which will make future relations with hospitals difficult. Long-range political and economic implications are beyond the scope of this presentation and are simply mentioned to indicate the anticipated difficulties of the PRO program in West Virginia.

Mr. Chairman, again thank you for this opportunity and I will attempt to answer any questions that you might have at this time.

Senator DURENBERGER. Thank you for ending on that note because that is the reality in which we all find ourselves. All we read about is Tom Dehn's example in Milwaukee of the elderly woman carried out on the back of the DRG, and who is responsible for the DRG—it is the folks up here. And as soon as the folks up here start getting that cost effectiveness, cost quality feedback, you know what they do—they abandon the system. So, the realities are here, and maybe each of you can address it from your State perspective. I would like a little comment on the interrelationship between what we are contemplating doing under peer review and what we used to do under PSRO, and the degree to which the diagnostic related groupings or the prospective payment mechanism are working or could work to facilitate the whole approach to practice pattern changes. And obviously, I would like from you maybe some hospital and physician—I stopped talking and the beeper went off—the lady in the red bag—I mean with the red bag [Laughter.]

Senator DURENBERGER. But something about the hospital and doctor reactions to some of the practice changes that come either from the payment system and/or from the work that peer review organizations are doing relative to inappropriate utilization.

Dr. DEHN. Senator, if I can use a nuclear analogy. I believe that the consciousness of physicians with regard to—certainly with regard to—acute care hospitalization has reached a critical mass. I think a number of elements is entered into that. Let me first tell you that in the hospitals that I practice in, we are looking at a decrease in admissions in the order of 10, 15, 20 percent. I won't comment upon my personal income, but it seems to be reflective of that.

The reasons I attribute to combinations of the media, a combination of the work done by the PSRO program in terms of enlightening physicians, certainly the HMO movement and business and industry—I think has all raised not only physicians but other providers' consciousness with regard to the conservation of resources and the appropriate use of particular health care settings. I think it goes across the board so that while the PRO Program looks directly at medicare, I believe that the spillover and the sentinel effect in the private sector is very significant.

Dr. WEEKS. I would echo what Tom says. I don't think we can blame everything that is happening on the PRO Program. We have had 2 years of a health care cost hype, justified to some extent. We are changing the whole system. We are rattling the tree, and a lot of people are playing games. Some, depending on the staff model, some trustees and administrators are saying, great, this is a good handle to get a hold of those docs. And the docs are reacting in the like fashion. Here is a line from one of the local papers in West Virginia in which the hospital announced an incentive plan for physicians, and if you come in under the DRG level for reimbursement, the hospital splits the money with the doctor. If it comes in over it, he gets his privileges lost.

So, the game is getting interesting, to say the least.

Senator DURENBERGER. Yes; but I know what that doctor is saying when the local politician comes through town.

Dr. WEEKS. Oh, sure. Sure, yes. Congressmen, they all get that one right in the neck.

Senator DURENBERGER. Certainly.

Dr. WEEKS. So, we do see these various gyrations going on. Hopefully, they will take some structured form here in the near future because there is a high anxiety titer in the medical community. On preadmission review, however, I have found a curious reaction. They would much rather have a preadmission certification program than to have the retrospective denial—the doctors I am speaking of. And so, we see these attitudinal adjustments depending upon the local scene. We are getting some open hostility. For the most part, I think they want direction. They, the physicians, they, the hospital administrators. How do I play the game? in the simplest of terms. Keep me out of trouble. I will do what you want. So, we are living in this sort of an atmosphere at the present time. I would simply like to conclude that I actually see a much better potential for educational efforts under the PRO Program than I did under the PSRO Program.

Senator DURENBERGER. Let me ask you a related question then. Obviously, there are a lot of other things happening out there, and that week I talked to you about is just full of experiences of people who are now—and one I remember very well is the woman telling me about her daughter who had a double hernia, and she went in at 10 o'clock and she was out at 2 o'clock, and she was just sick as a dog, and it was all those DRG's. And her husband nudged her and said, yes, but she was fine the next day, Martha, you know. The reality of how we perceive these changes, compared to the way it used to be—you spent 2 weeks in the hospital to have a baby—that is a part of our problem also. But I think it is right when doctors say that, for the first time, they have had to think seriously about economics, and they feel economic pressure. And I think it is real when they say that. It isn't a diminution in——

Dr. WEEKS. It is very real.

Senator DURENBERGER. Yes. And I think part of what we are trying to do here in discussing the role of peer review is how to deal with the realities of what that economic pressure is. Let me just ask you a question or two about West Virginia, Dr. Weeks. Just so we can all understand what a negotiable target is and what an objective is, and all that sort of thing, and just how you are going to implement it. One of your admission objectives in West Virginia appears to be to reduce 5,425 unnecessary admissions in 22 specific hospitals. Now, does that mean that you, in effect, have found 22 hospitals that you are targeting or——

Dr. WEEKS. That is a pretty high figure. That is probably, I would say, 90 percent of the total elective procedures in those 22 hospitals. This was a situation specific to West Virginia that we did, in fact, find 22 hospitals in a very good study in which we had found admissions that we had judged not to be necessary or enough that we could make this degree of projection. I am not sure we are going to come out on the nose, but we will probably hit the 5,000 level.

Senator DURENBERGER. Now, what is George Mitchell going to do in Maine? I mean, you were here when he was asking the questions about not having a "we" that had identified the 22 or——

Dr. WEEKS. I think anybody who used the PHDDS would have difficulty coming up with situation-specific information such as

this, but I think there are enough good references in the literature that they could take that same data and come up and apply within a reasonable proximity of that type of figure—the same type of information in Maine.

Senator DURENBERGER. Tom, do you have any comment on that?

Dr. DEHN. I agree with Harry. I think that a reasonable demographic review of the population makeup in Maine could be related to other similar States, even though the data would not be necessarily specific to Maine. It would be a starting point, and I think we heard earlier that Dr. Davis indicated that early goals may be renegotiated, and I think that that could be done. It looks like Maine is going to have to develop their own data base, and I don't think that they ought to be held accountable for the fact that they unfortunately did not have a data base and therefore were not awarded the contract.

Senator DURENBERGER. Senator Baucus, who you know is an author of the peer review legislation, has a question on the subject of State and local. And you all know we went mainly toward State-based peer review, but at the same time, it was intended, as he says here, that the program retain the local flavor that is needed if physicians and hospitals are to have confidence in the organization's familiarity with local conditions and practices. Thus, as with statewide PSRO's, it was proposed that local physicians would retain responsibility for reviewing care in their communities even though administrative activities would be carried out at a central location. How well do you believe—each of you—that this effort to centralize administration and continue local professional activities will work out under the PRO contracts now being negotiated?

Dr. DEHN. Harry.

Dr. WEEKS. I think there will be a loss of local flavor, not entirely, but I think we will see this.

Senator DURENBERGER. Tell me—as a practical matter—what you think.

Dr. WEEKS. There are a couple of places that real good peer review took place. One was in the continued stay review type of setting, and the other was in the reconsiderations of the denials in which we could get down to the nitty-gritty of discussing a case with the physician. And we are going to lose a certain element of that. We are supposed to call them up and talk to them and so forth, but it is not a sure-fire situation like it used to be. However, we still must be sending our review teams in, and we will be working within the same basic structure, but I think it is a little different twist—this program over the PSRO Program.

Dr. DEHN. I think most of us, Senator, have attempted to solve that problem by some form of regionalization, certainly more important in some States than in other States. Some States have relatively homogenous practices of medicine. Some are considerably different. I notice that—and though my numbers may be wrong—many of the States which are found to be unresponsive seem to be States that encourage subcontracting in order to preserve that kind of local flavor. And unfortunately, they were considered to be nonresponsive in some cases because of that attempt. In many cases, those States were States where I believe that subcontracting would

be important and would be advantageous. In our State, it was not a particularly important issue.

Dr. WEEKS. I would like to comment further. I think that you must keep in mind that this is sometimes used as a smokescreen for not going along with things. I have had situations in which I have been asked to furnish peer reviewers from out of the area simply because the peer reviewers in the area were not effective enough. And so, I always sort of buy things with a grain of salt when it comes to situations like that.

Senator DURENBERGER. But how about that element that went with the local idea—I think you mentioned it—being able to talk to the doctors? That is the one thing I have heard back in Minnesota that, you know, I am the peer reviewer, and it doesn't look right but I just wish I could talk to the doctor and——

Dr. WEEKS. I think if the PRO uses a little sense, they can keep that element going. For instance, I have got my physician reviewers filling out sort of a check sheet on quality of care problems, just to give me some idea of what they are running into whenever they review a chart—it is just sort of a check list. And they are sent to me once a week, and I sit down and categorize them and see where they are. And if I have got a problem, I put a local committee to work on it. Nobody is paying us to do this, but the bucks are ours and we can do it.

Senator DURENBERGER. All right. Thank you very much. If you want to remain, you are certainly welcome to.

We will now call Mr. Jack W. Owen, the executive vice president of the—somebody said—the very powerful American Hospital Association, and we might as well call up Dr. Alan Nelson, the member of the board of trustees of the American Medical Association, Salt Lake City, UT.

I appreciate both of you being here on behalf of your associations. I trust you were here for the Administrator's testimony as well as that of the peer review organizations. Your written statements will be made part of the record and you may feel free to comment on them, expand your remarks in any way you deem appropriate under the objectives that I set out for this hearing early on. Mr. Owen.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. OWEN. Thank you, Mr. Chairman. I will just comment briefly on my written statement since it is part of the record. I would first of all say that I am not here to jam up the system as Tom suggested the hospitals could do. We do believe in the PRO system per se, but we have some problems as you undoubtedly know. I think first of all the thing that we have to take into consideration is that the prospective payment system that we all worked on so hard is working, and it is working very well. Utilization is down. Even our greatest critics said that when that happened, hospitals would start admitting more patients—that is not true. Admissions are down along with it. And we still have some hospitals that are not even on the system yet, and the last large big group came on July 1.

Senator DURENBERGER. I am glad you made that comment, and I should have made it in introducing you because since it is an election year, politicians are taking credit for a lot of this, including my own party—they run large departments and things like that—and a whole heck of a lot of credit ought to be given to the hospitals of this country for getting out ahead of the inevitable, so to speak, and really helping us bring a lot of this about. I don't want to refortify that because it sounds self-serving coming from me.

Mr. OWEN. Right, but it is the hospitals and the doctors working together that has done it. Just our—our statistics show us that from January 1, 1984, through April that over-65 admissions have declined by 1.2 percent and this is the opposite of going up about 4 percent in other years. So, this is without any PRO operating. This is just the incentive system. The admissions—the length of stay has dropped to 7.5 percent for the over-65. So, we know that incentives work, and coming out of New Jersey, we saw that happen when DRG's went into effect there. The problem is that costs are not the only consideration. And the American Hospital Association had a position that we were opposed to PRO's, and we felt that a truly good prospective payment system would solve the problem of utilization and admissions, but we rescinded or reversed that decision a year ago and said that we would like to see, and we will support, PRO's, following along your bill, Senator, that quality of care must be taken into consideration and that our elderly citizens must be assured that the DRG system would not in effect hurt them through a lack of quality of hospitals or physicians discharging patients too fast.

And we have put out some brochures. We are supporting the program, and these are available and are in our hospitals. And we will continue to work as closely as we can.

The problem is that, like you, and I know that Dr. Davis does not believe that there are quotas here, but it is sort of—if it looks like a fish and it swims like a fish, and it tastes like a fish, and it smells like a fish, it is kind of hard to say it is not a fish. And that is what we are having a problem with on the so-called targets, measurements, or what have you as to whether they are quotas or not.

We are concerned that, as is Dr. Davis and the Department, the press has picked up the so-called avoidable death issue, and it came out of the contracts. It is understandable how and why they did it. The problem is that that leads to a destruction of the confidence in our elderly when they are in hospitals, that there are deaths that could have been avoided. And I don't think that was the intent of the PRO's or the Department, and certainly I would argue that those avoidable deaths are avoidable as has been referred to.

It is interesting that the part of that stems, as I listened to the PRO's talk about how they are going to meet their targets, a lot of this goes back to the way hospitals kept their medical records before this system began. And if you are going to be paid on the medical record versus how you take care of a patient, you have a difference in the way that medical record is interpreted. The principal diagnosis versus primary discharge or admitting or whatever other kind of diagnoses were being used. I wonder if some of those so-called avoidable, unnecessary things that are occurring are not a

fault of the way the record-keeping was, and as we get more hospitals into the system and improve the record-keeping from the standpoint of how DRG's work, we won't find some of that disappear. We certainly know—and next week when you have the oversight hearings on the pricing—that that so-called DRG creep or improvement in medical record-keeping has changed the waiting that has occurred. I would like to know that the PRO's have taken that into consideration when they have reviewed exactly what has happened. At the same time, I am sure that some of these so-called avoidable or unnecessary procedures occur because a patient goes into a hospital that is not a university hospital or does not have the kind of equipment or technology available that a larger hospital might have had, and that they are looking at a full State and saying that there are so many of these patients who should have not had this particular procedure and this shouldn't have happened to them. Then, maybe they are saying in effect they should have gone to a higher cost hospital. It is interesting when you think about that. When the Congress in its wisdom took away our 1 percent for technology, which would kind of improve the whole position of increasing avoidable accidents, at the same time we are talking about a national rate which is going to level out so that these so-called higher cost high-technology places could disappear and we may not have anything like avoidable deaths any more because everybody would be the same. The deaths will be the same but they won't be called avoidable because everybody will be treating everyone the same way.

The other thing that we are concerned about is—as you listen to this testimony—that the PRO's who are setting their objectives are setting them without the hospitals that are going to have to provide the service. And that is one of our biggest concerns—communication. And Tom mentioned it briefly. We have got to instill the communications between the PRO, the hospital, and HCFA so that there is a feeling of working together, because for me to go out and negotiate a contract for somebody else who has to deliver the care, it makes it rather easy for me to do, but very difficult for the doctors and the hospitals who are on the firing line.

I would just like to talk about three things, if I could, that we are concerned about, and one of them I have already covered, and that is the so-called guidelines for a target. And again, we recognize that the purpose of the admissions reviews, the detected admissions that are not medically necessary or appropriate, but these guidelines and these targets seem to be based mostly on saving money. And once the so-called easy reductions are accomplished, that is procedures which could be performed on an outpatient basis, or patients that are readmitted in inappropriate admissions by specific practitioners, then the PRO in order to meet its savings objectives must be necessity review more and more cases, seeking reductions in admissions whether appropriate or not. This worries us. Medicine is not an exact science. It is an art, and it is dependent upon professional judgment, not numbers that are calculated to meet an economic goal.

The second thing is the waiver of liability, and that was discussed briefly by the two previous witnesses, and that has to do with the 2.5-percent favorable presumption. In the past, if a hospi-

tal had favorable presumption, if they could meet the 2.5 percent of the total medical medicare days in a quarter, if they were not considered inappropriate or unnecessary, and now it is 2.5 percent of admissions being reviewed. There is an administrator sitting several rows back of me—Carter Melton from Harrisonburg, VA, who was telling me a few hours ago about his going through such a review. I am sure if you had any questions for him, he would be happy to answer them, but as you said there will be other hearings, and I am sure he will want to be here, but for him to now get favorable presumption, he is going to have to have 99.85 percent of all admissions that come into his hospital medicare admissions that are neither unnecessary—that are known about—or are inappropriate. And that is almost impossible in an art of the practice of medicine. When a physician has to act on his best judgment when a patient comes to see him. The other thing that we are concerned about is that some of our local PRO's, and we are getting stories now around the country, who have ruled in favor of the hospital on a particular case once they were being reviewed, and said the hospital was right, have been overruled by the regional office of HCFA because you are not going to meet what your objectives are.

And we are quite concerned that this will continue. The last one has to do with denials, and here our concern is that some of the denials that we are seeing hospitals get—the PRO is just saying payment denied. And that defeats the whole purpose of the educational program that Dr. Davis and all of us would like to see happen. If there is a problem and it can be corrected and we need some education, then we need something more than just payment denied. We need a chance to sit down with the hospital and the doctor in order to correct that. I think as far as recommendations that we would have—and we are happy to work with the PRO's and HCFA—is that I think first we have got to open communications between the PRO's and the providers so that they understand what is going on. I think that we have to assure the providers that there is due process in the conduct of the review, both in opportunities for comment on proposed review criteria and procedures. And then I think finally that we would like to see HHS establish positive incentives for hospitals and physicians with good review records by allowing flexible review procedures and a delegation of those functions for which the hospital has demonstrated the effectiveness of its in-house program. And I think, again, that was brought out before that when you have a bad apple, you don't necessarily have to go to the full barrel in order to get rid of the bad apple. And with that, I would close, Mr. Chairman, and I will take any questions you might have.

Senator DURENBERGER. Before I go on to Dr. Nelson, and I will be asking you both some questions later, would you expand just a little bit on the subcontracting section of your statement. That came up a little earlier. It is a concern of Senator Baucus.

Mr. OWEN. The problem that we are concerned about is that when a statewide review system has been named and then there is a subcontract with, say, local agencies closer to the hospital, that the hospital that is being reviewed will have an opportunity to work closely with the contracting agency. And we are afraid that some of that may slip away where the rural, small hospital is far

away from the so-called PRO contractor, and he doesn't subcontract anywhere around—that hospital will not have the benefit of the quality review that could occur and has been occurring where it is done closer to the individual hospital. That is, I think, what Senator Baucus is most concerned about, and we are, too, that that opportunity does exist.

[Mr. Owen's prepared written statement follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE
OF THE UNITED STATES SENATE
ON
IMPLEMENTATION OF THE PEER REVIEW ORGANIZATION PROGRAM

JULY 31, 1984

SUMMARY

The American Hospital Association (AHA) supports the development of an effective utilization review program focused on the quality and appropriateness of care provided under Medicare. The Association is concerned about the program being implemented by the Department of Health and Human Services (HHS), in response to the Peer Review Improvement Act of 1982, which authorized replacement of Professional Standards Review Organizations with Peer Review Organizations (PROs). The AHA's concerns center on the program's objectives; timing of issuance of regulations and minimal opportunity for public participation; and centralization of review, with its cost shifted from the PRO to the hospital. In view of these concerns, the Association recommends that there be full, open communication between PROs and providers, assurance of due process in the conduct of review, allowance for provider representation of beneficiaries, and flexible review procedures with delegation of certain review functions.

GENERAL COMMENTS

Mr. Chairman and Members of the Subcommittee, I am Jack W. Owen, executive vice president of the AHA, which represents over 6,100 hospitals and health care institutions, as well as more than 38,000 personal members. On behalf of the Association, I welcome this opportunity to comment on the implementation of the PRO program and commend you for your timeliness in holding this hearing to review potential problems concerning it.

Hospital Perspectives

The AHA's primary concern is that the people in the communities served by its hospitals get the care that they need. Toward that end, the AHA supports the development of an effective utilization review program that focuses both on the quality and appropriateness of care. The Association also strongly backs the use of physician-sponsored peer review to evaluate medical care provided to Medicare patients.

However, the AHA does not support the use of utilization review to set quotas based on national formulas that reduce access to care, without reflecting local needs and circumstances. The Association opposes a utilization review program that does not distinguish sufficiently among individual hospitals or physicians with regard to the quantity or type of review. Such a program ignores provider performance and effectiveness in managing the quality and appropriateness of care.

The AHA is particularly concerned about the following aspects of PRO program implementation:

- the basis for, and use of, PRO objectives;

- the extent to which the PRO program is being implemented without issuance of regulations and with minimal opportunities for public review and comment; and

- the extent to which review is being centralized and the cost of review shifted from the PRO to the hospital.

Prior to exploration of these points, it seems useful to review hospital performance, especially the way in which hospitals are responding to the incentives established by prospective pricing.

Current Industry Performance

The PRO program was created as part of a broader strategy to contain the rate of increase in Medicare expenditures. Rising utilization has accounted for a substantial part of the increase in Medicare expenditures over the past decade. The recent performance of the hospital industry offers substantial evidence that incentives are bringing about a major change in hospital costs. The rate of increase in total hospital expenses slowed from 15.8 percent in 1982, to 10.2 percent in 1983. The rate of increase in inpatient expenses fell even more sharply: from 15.6 percent in 1982 to 9.6 percent in 1983. Early data for 1984 indicate a continuation of these trends: the annualized rate of increase in total expenses for the first four months of the year was 5.2 percent compared with that for the same period last year.

Contributing to these trends is a marked moderation in utilization. Total admissions declined one-half of one percent during 1983, after remaining stable in 1982. Admissions of patients 65 years of age and older increased 4.7 percent during 1983, slightly below the historical trend. Length of stay for patients 65 years of age and older was down sharply--4.5 percent--resulting in almost no net increase in total patient days for patients in this

category. The picture is more clearly drawn in the fourth quarter of 1983, with admissions of patients 65 years of age and older increasing by less than 1 percent, while the average length of stay for these patients fell 5.5 percent. Through April of 1984, admissions of patients over the age of 65 actually declined by 1.2 percent, compared to the same period in 1983, while the length of stay for patients over the age of 65 declined by 7.5 percent.

In addition to these trends in utilization, the increase in hospital staffing levels is slowing, and the overall increase in hospital costs is moderating.

The significance of these trends is readily apparent. Hospitals are responding positively to the incentives created by both prospective pricing and the system of per-case payment established by the Tax Equity and Fiscal Responsibility Act of 1982. It is important to note that hospitals are not reacting inappropriately to prospective pricing incentives by increasing admissions.

SPECIFIC PRO IMPLEMENTATION ISSUES

PRO Objectives

The recent performance of the hospital industry is strong evidence that incentives are powerful tools for containing costs in the Medicare program. However, when the performance of the program is evaluated, cost is not the only factor that should be taken into account. More important are the needs of the growing Medicare population and the kind of Medicare system that is required to meet those needs, now and in the future. The past decade has seen

dramatic improvements in the treatment of heart disease, cancer, and stroke--the three leading causes of death among the elderly--and a continuing increase in the life expectancy of the elderly. The prices of these gains are greater utilization and increased total costs.

These considerations are particularly relevant to the establishment of goals and objectives for the PRO program and for PROs themselves. Recently, there has been a great deal of public uneasiness that the objectives being set for PROs may lead to utilization quotas for the Medicare population. This uneasiness first emerged during the contract negotiation process when rumors persisted that prospective contractors' proposals were being evaluated against unannounced "savings-to-costs" objectives. Even if such rumors are without basis, HHS' reluctance to clarify program objectives and to conduct an open contracting process remains problematic. The source of the AHA's concern is not the establishment of quantitative objectives, because measurable goals are essential if program administrators, hospitals, physicians, beneficiaries, and the public are to understand the direction in which the program is headed. The source of concern is, rather, the lack of clarity in PRO objectives' origin, structure, and use.

The AHA believes that legitimate PRO objectives should meet several basic criteria:

- All objectives should be based on quality of care and access--i.e., medical--considerations, rather than on financial considerations.

- Objectives should reflect local needs and circumstances, including the age and sex of the population served, local standards of medical practice, and the range of services available in individual communities.

- Objectives should be based on identified problems, and should address unnecessary or inappropriate utilization.

- Objectives should take into account the many non-medical factors that affect utilization patterns, such as the ability of patients to travel to receive services and the availability of support for patients at home.

While some of the objectives in the early PRO contracts may meet these criteria, others clearly do not. For example, the PRO in Tennessee is pledged to eliminate nearly 92,000 admissions during the two-year contract period. For another example, the PRO contract for Kentucky calls for a reduction of more than 36,000 admissions over two years. These objectives make no reference to reductions in inappropriate admissions. To date, in the absence of the analyses supporting the objectives, it is impossible to determine if studies in these states have confirmed the existence of such levels of unnecessary admissions.

Other Kentucky and West Virginia objectives call for reductions in the total number of discharges from individually identified hospitals. Even if the

identified hospitals work with their PROs to reduce or eliminate unnecessary utilization, it is possible that the objectives will not be met if the hospitals' shares of total discharges rise because of effective competition with other hospitals (or for other reasons, such as care to patients injured due to natural disasters). Any attempt to apply these objectives inappropriately would violate several federal laws, including, at a minimum, Medicare statutes. Additional examples can be found in other PRO contracts signed thus far.

Several characteristics of these objectives are troublesome

- The methods used to establish the objectives have never been specified publicly. There are indications that deviations from national utilization rates were used both to identify potential problem areas and to establish objectives. National utilization rates are used appropriately only to identify potential problem areas. Specific achievable objectives should be based only on studies that confirm the existence of a problem and identify its causes.

- The studies used by the PROs to set objectives were not made available for public comment prior to negotiations, even though the PRO contracts could have been structured to provide opportunities for public review and discussion of proposed objectives.

- The PRO contracts were negotiated under extremely short time schedules, due largely to the passage of nearly 18 months between the enactment of the Peer Review Improvement Act and the issuance of a Request for Proposals (RFP). Nevertheless, the contracts provide that only HHS' Health Care Financing Administration (HCFA), "at its option," can initiate a re-evaluation of contract objectives if it appears that the objectives agreed to during the initial negotiation are unrealistic or inappropriate.

- The failure of objectives to refer universally to reductions in inappropriate utilization may force some PROs to attempt to deny payment for necessary care or face cancellation of their PRO contracts.

These problems can be solved, provided that HHS is willing to observe its legal obligations. Opportunities for public review and comment can be built into PRO contracts and procedures. PROs can be given an opportunity to revise inappropriate objectives if more intensive study of potential problem areas reveals new information. HHS can require not only the careful wording of PRO objectives but also rigorous documentation of problems, to avoid placing PROs in a potentially untenable position of trying to meet an objective based on faulty premises. The AHA is anxious to work with HCFA and PROs to establish realistic, yet meaningful, objectives that will ensure the delivery of needed services to the Medicare population.

Public Accountability

One of the most troubling aspects of the PRO program has been HHS' delay in publishing necessary regulations governing implementation of the PRO program. In delaying publication of critical regulations, HHS has undervalued the benefit that can be derived from public comment in shaping sound public policy. This approach precludes a smooth and workable transition to a review program:

- where the policies adopted are sensible and practical;
- where national goals are addressed in full recognition of local conditions and without sacrificing community needs;
- where the delivery or receipt of needed services is not disrupted by "surprise" new policies implemented without adequate notice to hospitals, physicians, or beneficiaries; and
- where PROs are not faced with daily uncertainties regarding their ability to fulfill their contractual commitments.

This situation represents a serious breach of HHS' obligations to provide for public accountability and to meet the specific requirements of the Administrative Procedures Act.

Specifically, the PRO program is being implemented without issuance of final regulations governing the conduct of review, the reconsideration and appeal

process, the sanctions procedure, or the acquisition and disclosure of data by PROs. Notices of Proposed Rulemaking (NPRMs) on the acquisition and disclosure of data and the sanctions process were not issued until April of this year, almost 20 months after passage of the Peer Review Improvement Act, while the NPRMs on the conduct of review and on the reconsideration and appeals process were not issued until this month. It is likely that final rules cannot be issued until this fall, more than two years after passage of the enabling legislation, and more than three months after PRO contracts have been signed and PROs have begun to conduct review.

Because of the delays in issuing NPRMs, the public comment period has been limited on all substantive regulations to 30 days, which provides little time for dissemination of the proposed rules to hospitals and the preparation of informed, constructive comments.* Similarly, the uncertainty surrounding the content of the final regulations requires PROs to conduct review without being able to establish consistent review policies or procedures. In addition, in anticipation of PRO contracts, HCFA has already implemented several substantive changes in medical review policies and procedures by issuing instructions through transmittal letters and other non-public channels to the PSROs (many of which are bidding for PRO contracts) and the fiscal

* In response to a formal expression of these concerns by the AHA, the HCFA Administrator took the position that the decision to allow for comment rested with the discretion of the agency and that, in the agency's view, time did not permit additional formal or informal public comment.

intermediaries that currently conduct review.* These changes and revisions were imposed on hospitals without notice and were incorporated into the HCFA RFPs and the PRO contracts now being signed, thus remaining outside the purview of public scrutiny.

The absence of adequate opportunity for public comment or notice on regulations and administrative transmittals apparently will carry over to the assumption and conduct of review by PROs. Hospitals are being given little opportunity for meaningful negotiation of PRO agreements. The recently enacted extension of the deadline for establishing hospital agreements with PROs is helpful in providing time for the development of adequate agreements, but HHS claims that PROs are required to allow PROs access to hospitals within 30 days of signing their contracts with HCFA. Similarly, some hospitals are experiencing difficulty obtaining the written medical criteria used by the PRO to conduct review, and are concerned that they may face denial of payment due to unannounced changes in review policies.

Nonetheless, the AHA is committed, in good faith, to the establishment of effective working relationships between hospitals and PROs. We recently distributed to all member hospitals a special briefing on the PRO program, including a discussion of constructive ways of approaching the development of a hospital/PRO agreement. We are monitoring the negotiation of hospital/PRO

* Additionally, several other changes in review policies were included in the prospective pricing implementing regulations which were first published as interim final rules, again, without prior notice and comment.

agreements and will keep both HCFA and Congress informed of any problems that may arise.

However, the AHA cannot accept HHS' continuing disregard of administrative procedures. It is clear that HHS and the Office of Management and Budget have unilaterally decided how the PRO program will be implemented and are entrenching firmly those decisions in PRO contracts. By using the contracting process in this way, HHS has effectively deprived hospitals, whose activities are regulated by these contracts, of the opportunity for meaningful comment that the law guarantees.

More important, however, is the dilemma that if, in publishing final regulations later this year, HHS revises the regulations based on public comment, PRO operations will be disrupted and PRO contracts may have to be renegotiated. If HHS does not make any revisions in the final rules in response to public comment, the program will lose the benefits of meaningful public participation.

Centralization of Review

The PRO program as it has emerged over the past several months will be a highly centralized and formulistic program. It will provide few rewards for those hospitals that have effective in-house peer review programs and will not yield the level of efficiency or cost-effectiveness contemplated by Congress.

The Peer Review Improvement Act explicitly allowed a PRO to establish a subcontract with a hospital for those review functions that the hospital had a

demonstrated ability to perform. In implementing the program, HHS, in the absence of public comment and any evidentiary basis, has rejected the idea of hospital-based review, except for those quality review functions that have no bearing on payment. As most of the quality objectives written into the PRO contract have some impact on payment, essentially all review will be performed by the PRO itself.

The Peer Review Improvement Act also encouraged the use of subcontracts between the PRO and local review organizations. Such subcontracting has been sharply restricted by HCFA. This policy has several effects:

- Most review will be conducted outside of the hospital, at the PRO central offices, necessitating the photocopying of large numbers of medical records.* Proposed regulations prohibit the PRO from paying hospitals for the costs incurred in copying and shipping medical records, and the PRO's contract includes no funds for this purpose. HCFA reasons that the cost of copying and transporting medical records was covered under cost-based reimbursement and is, consequently, reflected in DRG prices. However, as the volume of records demanded has increased sharply under the new review procedures, any costs that were

* We note, in addition, that HHS' proposed regulations violate Congress' expressed limitations on such informational demands, as well as the statutory limitations on public disclosure of confidential information.

in the historical cost base of the hospital are far less than those currently borne by hospitals. This unauthorized cost-shifting will obscure the true cost of HCFA's implementation approach and contravenes the Medicare statutes.

- PROs will experience difficulties in having local physicians conduct review, as the physicians must have ready access to the PRO offices. This effect will be particularly noticeable for small, rural facilities located in remote parts of a state.

- PRO staff will have limited contact with the hospitals and physicians whose patients are under review. Opportunities for discussion will be severely limited, reducing the educational effects that are part of the intrinsic value of peer review.

In addition, many of the formulas established as part of HCFA's utilization review program fail to distinguish between hospitals with good review records and hospitals with utilization problems. Regardless of hospitals' review experience, they can expect to have a minimum of 25 to 35 percent of their cases under review. Because many of the screens are set at extremely low levels, many hospitals may experience much higher levels of review even though the care they are providing is found to be necessary. Prospective pricing has shown the ability of positive incentives to improve hospital efficiency. Positive incentives should also be used to promote appropriate hospital use.

By adopting a formulistic approach to the required areas and levels of review, HHS also is building inefficiencies and inequities into the review program.

For example, every single outlier case must be reviewed in detail, regardless of whether the hospital and physician involved in the case have already demonstrated that the care provided on an outlier basis is always reasonable. Another example is the requirement that PROs perform 100 percent preadmission review of all elective admissions in at least five DRGs, regardless of whether the individual hospitals and physicians involved have demonstrated any pattern of unnecessary or inappropriate admissions for any of the selected DRGs.

These problems can be solved, given a commitment to make a locally based peer review program operate effectively. Delegated review can work, as has been shown by private sector review programs, if hospitals have strong incentives to establish effective in-house programs. A Medicare program that encourages the development of strong hospital-based systems would better serve Medicare beneficiaries than one that removes the incentives to make utilization review a central part of hospitals' internal management structure.

CONCLUSIONS AND RECOMMENDATIONS

The AHA fully supports the establishment of a properly developed and cost-effective Medicare utilization review program, and is eager to work toward that end with both HHS and Congress. In doing so, the Association emphasizes that the only factors that should be considered in developing such a program are clinical and the only question that should be asked is whether the services provided to individual patients are necessary and appropriate.

Ultimately, physicians and hospitals are responsible for the appropriate treatment of individual patients. PROs cannot substitute for the professional

judgments of physicians. They cannot bear the legal and ethical responsibilities of hospitals for ensuring quality of care. Consequently, physicians and hospitals must be integral parts of the PRO program, and must participate in developing PRO objectives, review criteria, and procedures. This cooperation clearly was intended when the Peer Review Improvement Act was written. Only if there is a partnership can the needs of the Medicare population be met.

The essential first step is to establish full, open communication between PROs and providers. All studies, data, and methodologies used to identify problems and establish review objectives should be available for public review and comment, provided that the confidentiality of sensitive data is protected. Providers targeted by a PRO's use of HCFA objectives must be given an opportunity to review and submit comments on the PRO's analysis of their utilization patterns.

Another step is to assure providers due process in the conduct of review both in opportunities for comment on proposed review criteria and procedures and in objective review of PRO determinations on medical necessity and appropriateness. Particularly important are the establishment of an effective reconsiderations process and the creation of protections against unreasonable retrospective denial of payment.* The development of well-designed preadmission review programs can make a substantial contribution toward this goal.

* We note, for example, recent public statements by a HCFA official proposing the imposition of sanctions on providers that initiate "frivolous" appeals. Such a proposal can only be intended to chill the exercise of legal rights.

Still another step is resolution of the difficulties of patients having few, if any, incentives to appeal retrospective denial decisions and of hospitals being prohibited by statute from appealing denials beyond reconsiderations by the PRO itself. Recent instructions from HCFA also prevent Medicare patients from obtaining providers' assistance and representation in appeals, forcing the beneficiaries to bear the costs of any administrative or judicial proceedings. While resolution of such problems may require legislative action, HCFA can avert significant short-term distress by reversing its position on provider representation of beneficiaries.

Yet another step is for HHS to establish positive incentives for hospitals and physicians with good review records by allowing flexible review procedures and the delegation of those functions for which the hospital has demonstrated the effectiveness of its in-house program. The Peer Review Improvement Act, written and initiated by your Subcommittee, was designed to provide PROs with this flexibility, as well as the capacity to establish peer review programs that reflect appropriate, as well as inappropriate, provider behavior.

In offering these recommendations, Mr. Chairman, I thank you for the opportunity to present them, with the hope that an effective PRO program--focused on the quality and appropriateness of care--will be implemented.

Senator DURENBERGER. On Dr. Weeks' response that you can put together a statewide organization that is locally sensitive—that was part of his response—one of my concerns obviously is the flip side of George Mitchell's not having a PSRO in his State. There are some States that lend themselves to regionalization—Florida, for example, always comes to mind—I don't know how they have solved the problem—but where you have existing PSRO's in disparate metropolitan areas, my reaction has always been why not have the subcontracting process just to maintain those existing organizations. I think that what has happened out there is that they have just folded into one or something like that.

Mr. OWEN. That appears to be the case, and you take a place like Maine, where you have a lot of geography and the population along the coast, and then it is kind of open—in fact, further inland—and you don't have the opportunity or the transportation back and forth as easily, and that is true in a number of States—Montana would be another one where you have got a spreadout kind of State where it would be difficult.

All right. Dr. Nelson, thank you, too, for being here. Your statement, too, will be made part of the record, and you may proceed in any way you wish.

STATEMENT OF DR. ALAN NELSON, MEMBER OF THE BOARD OF TRUSTEES OF THE AMERICAN MEDICAL ASSOCIATION, SALT LAKE CITY, UT

Dr. NELSON. Thank you, Mr. Chairman. I am Alan R. Nelson. I am a physician in private practice in Salt Lake City, UT. I am an internist. In 1971, the Utah State Medical Association asked me to establish the Utah Professional Review Organization, which subsequently became the first PSRO, and now is the peer review organization for Utah. And Ross Rubin is accompanying me. Ross is director of the AMA's Department of Federal Legislation.

First, we want to reiterate our strong support—that is, the AMA's strong support—for medical peer review that emphasizes quality assurance. And I would like to detail some of the activities that the AMA is engaged in to encourage and assist State medical societies to become involved in PRO. This includes two nationwide PRO conferences, a prebidders conference when the RFP was issued. The AMA produced a technical manual for State societies, conducted debriefings following the bidders conference, and we have provided consultants to assist States who wish to contract to become PRO's. And we are pleased to report that 47 State medical societies have either submitted PRO contract proposals or are supporting the bid of their local PSRO. We also would like to commend Congress for extending to November 15, 1984, the deadline by which hospitals must contract with a PRO in order to continue to be eligible to receive medicare reimbursement. However, there isn't much time between now and then, and it is possible that additional time may be necessary to avoid a cutoff of medicare reimbursement to hospitals. And we urge Congress to continue to closely monitor the implementation of the PRO Program and to extend the deadline again if such becomes necessary.

We are also pleased that Congress has extended to November 15 the preferential treatment for physician sponsored and physician access organizations. We remain concerned over the possibility that payor organizations will be awarded PRO contracts. We think it is important for physician organizations to be engaged in this kind of review, both from the standpoint of encouraging needful change and also encouraging the activity of physicians in doing this work on behalf of their patients. While we approve of peer review organizations establishing goals for improving quality, the AMA is particularly concerned over provisions exacted in PRO contracts that may be misapplied and become quotas that reduce quality. And, of course, that has been spoken to at length already in this hearing. We recognize that these contract objectives are intended to be goals rather than quotas but, in practice, they may have the effect of encouraging overzealous PRO's to deny appropriate as well as inappropriate admissions in order to meet his contract objectives.

And the AMA is also very concerned that HCFA's preadmission review requirements are too inflexible. These requirements whereby all admissions of DRG's would be reviewed will result in the performance of many unnecessary reviews and thus be a waste of scarce PRO resources. We are concerned about the inflexibility of the fixed price contract approach set forth in requests for proposal issued by HCFA. We believe that the 2-year fixed price contract involves a substantial and unreasonable degree of risk to PRO's and this risk is increased by the fact that many PRO tasks have never been widely performed and the fact that their underlying functions are not under control. In concluding, we recommend that each PRO contract should explicitly acknowledge a PRO's right to renegotiate the terms of its agreement based on its experience under the contract. The AMA strongly supports medical peer review that emphasizes quality assurance and continues to assist State medical societies in their efforts to become involved in the PRO Program. In recent months, considerable progress has been made in the implementation of the PRO Program. However, as discussed above, a number of serious problems exist. Mr. Chairman, many State society leaders who invested time and money in a commitment to peer review are disillusioned and disheartened following an earnest and good-faith effort to establish a PRO and have felt thwarted by the inability to obtain data, the lack of published regulations, an RFP that is nightmarish in its detail, and a contract process that sometimes has been rigid and sensitive-prescriptive, and sometimes downright unrealistic.

The AMA commends the committee for this hearing and its interest in close oversight of PRO implementation. We urge you to continue to closely monitor the program to ensure that the concerns expressed above are adequately addressed. I might also say, Mr. Chairman, that today we have had the advantage of hearing from those who are already saved, that is Dr. Weeks, Dr. Dehn represent—and to some degree, my association in Utah has also been with—successful organizations—mature PSRO's who faced a different set of challenges and problems in trying to implement this program than did a State medical association that inherited a territory in which perhaps there was no PSRO or a State medical association that sincerely felt that it could improve the current situa-

tion in an area where perhaps there were conflicting PSRO's or PSRO's with uneven or checkered records.

When the leadership in that society picked up the RFP, tried to find some good consultants, with all the technical assistance that the AMA could provide for them, they faced formidable challenges. And I think that the intention of the legislation was to facilitate meaningful peer review by diligent and earnest organizations of physicians who were seeking to improve the quality and efficiency of medical care. That may not be translated then into an opportunity for them when they find themselves competing with people who have been around the contract track often enough that they—as has been said—know how the game is played. And ultimately, the best needs of our patients in our society may not be served. Thank you.

[Dr. Nelson's prepared written statement follows:]

Statement of the American Medical Association

to the

Subcommittee on Health
Committee on Finance
United States Senate

Presented by

Alan R. Nelson, M.D.

RE: Implementation of the Peer Review Organization Program

July 31, 1984

American Medical Association
535 N. Dearborn Street
Chicago, Illinois 60610

Department of Federal Legislation
Division of Legislative Activities
(312) 751-6741

39-958 O—84——8

PRINCIPAL POINTS IN THE STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Finance
United States Senate

RE: Implementation of the PRO Program

July 31, 1984

- The AMA strongly supports medical peer review that emphasizes quality assurance.

- The AMA continues to actively assist state medical societies in their efforts to become involved in the PRO program.

- The AMA commends Congress for extending the period of preferential treatment for physician-sponsored and physician access organizations and urges Congress to take any additional action necessary to ensure that the preference for physician peer review is effected.

- The AMA commends Congress for extending the deadline by which hospitals must contract with a PRO in order to continue to be eligible to receive Medicare reimbursement. Congress should closely monitor implementation of the PRO program and extend the deadline again if such action is necessary to avoid a cut-off of Medicare reimbursement to hospitals.

- The AMA is very concerned about the inflexibility of the fixed-price contract approach mandated by the Health Care Financing Administration for PRO contracts.

- The AMA believes that HCFA's pre-admission review requirements are inflexible and will result in the performance of many unnecessary reviews.

- The AMA is concerned over provisions in PRO contracts that establish objectives of reducing a particular type of admission by a specified amount. These objectives may encourage overzealous PROs to deny appropriate as well as inappropriate admissions in order to meet their objectives.

- The AMA believes PROs should not be held responsible for reducing their area's overall Medicare admission rate because to do so could encourage PROs to deny appropriate as well as inappropriate admissions.

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STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Finance
United States Senate

Presented by

Alan R. Nelson, M.D.

RE: Implementation of the Peer Review Organization Program

July 31, 1984

Mr. Chairman and Members of the Committee:

My name is Alan R. Nelson, M.D. and I am a physician in the practice of internal medicine in Salt Lake City, Utah. I am a member of the Board of Trustees of the American Medical Association and was one of the founders of the Utah professional review organization which subsequently became the nation's first professional standard review organization (PSRO). Accompanying me is Ross Rubin, Director of the AMA's Department of Federal Legislation. The AMA is pleased to have this opportunity to testify before this Committee concerning the implementation of the Peer Review Organization (PRO) program.

Mr. Chairman, in testimony before this Committee six months ago, the

AMA expressed its firm support for medical peer review focusing on quality assurance. The AMA wishes to reiterate its strong support for medical peer review that emphasizes quality assurance. During the past months we have continued actively to encourage and assist state medical societies in their efforts to become involved in the PRO program. We are pleased to report that 47 state medical societies have either submitted PRO contract proposals or are supporting the bid of their local PSRO.

Mr. Chairman, in our previous testimony we voiced concern that the lengthy delay which had occurred in implementing the PRO program could result -- contrary to Congressional intent - in two extremely undesirable occurrences: one, review being performed by non-physicians, and another, hospitals losing their Medicare reimbursement. We urged Congress to extend the time during which fiscal intermediaries are prohibited from qualifying as PROs. We also advocated that the deadline for hospitals to contract with a PRO be extended in order to ensure that Medicare beneficiaries continue to have access to hospital services.

The AMA is pleased that Congress has acted to extend from October 1, 1984, to November 15, 1984, the period of preferential treatment for physician-sponsored and physician-access organizations — again stating its preference for peer review by the profession. In addition, we commend Congress for extending to November 15, 1984, the deadline by which hospitals must contract with a PRO in order to continue to be eligible to receive Medicare reimbursement. It is unthinkable that the elderly might be denied their Medicare benefits by denying access to needed hospital care.

We are also happy to report that in the past six months progress has been made in the implementation of the PRO program. A final rule dealing with the issues of PRO area designation and definition of eligible organizations has been published. The request for proposal for PRO contracts has been issued and 17 PRO contracts have been signed. In addition, rules dealing with the issues of confidentiality of PRO information, PRO sanctions, reconsiderations and appeals, and conduct of review have been proposed. Despite this progress, however, the AMA has a number of significant concerns regarding the implementation of the PRO program. These concerns are set forth below.

Deadline for Hospital Contracts

The AMA is concerned that hospitals will not have contracts with PROs in their area by November 15th. To date, 19 organizations have been awarded PRO contracts. Thus, only in these 19 states can a PRO begin the potentially lengthy process of negotiating contracts with all of the hospitals in its area. In the remaining states, PRO contracts must still be awarded before the negotiating process can even begin and before subsequent agreements with hospitals can be signed.

With only 3-1/2 months to go, it is likely that additional time beyond November 15 will be needed to avoid a cut-off of Medicare reimbursement to hospitals. Denying Medicare reimbursement to hospitals could have a disastrous effect on access to and availability of health care for our nation's senior citizens and on our health care system. Hospitals would be faced with the choice of (1) treating only those elderly persons who could demonstrate an ability to pay, or (2) treating

such persons and shifting the costs of treating those who are unable to pay to all paying patients. Either choice is totally unacceptable. Thus we urge Congress to continue to closely monitor the implementation of the PRO program and to again extend the deadline for hospitals to contract with PROs if such action is necessary to ensure that the nation keeps its commitment to Medicare beneficiaries.

Medicare Peer Review by Payor Organization

The AMA remains concerned over the possibility that payor organizations will be awarded PRO contracts. Such action would undoubtedly have a serious adverse impact on the PRO program. We believe strongly that the success of the program is dependent largely on the expertise of the reviewing entities and the confidence and cooperation of local physicians. Review performed by physicians can best secure the support and confidence of their fellow physicians.

The AMA is also concerned that if payor organizations are permitted to assume review functions, the PRO program, like the PSRO program, will emphasize cost containment rather than quality assurance. The arbitrary reductions, such as in number of admissions, exacted of PROs by HCFA in the contract process make all too real the pursuit of arbitrary cost reduction. Thus we urge you to continue to closely oversee the implementation of the PRO program and to take any action necessary to ensure that the Congressional preference for physician peer review is carried out.

Fixed-Price Contract

The AMA recognizes that PROs must assume some degree of financial

risk under the PRO program. However, we are very concerned over the inflexibility of the fixed-price contract approach set forth in the request for proposal issued by HCFA. We believe that a two-year fixed-price contract involves a substantial and unreasonable degree of risk to PROs. This risk is increased by the fact that many PRO tasks have never been widely performed, and the factors underlying their functions are not under control. For example, PROs have no experience in performing outlier review or other functions specifically related to the new prospective pricing system.

As a result, the cost of such review could substantially exceed the amount that PROs have projected for such activity. The AMA recommends that each PRO contract should explicitly acknowledge a PRO's right to renegotiation based on its experience under the contract. It is to be expected that PROs will have to demonstrate competence and bona fide efforts at compliance. Mr. Chairman, we are not advocating a contractual loophole through which the PRO may reach a protected sanctuary. Not at all! The PRO must remain accountable for substantial compliance for all elements of the contract not beyond its control.

Pre-Admission Review

The AMA is also very concerned about HCFA's requirement that PROs perform preadmission review on all elective cases in five of the twenty most prevalent DRG categories. An exception would be allowed only if the PRO could document that greater cost savings or a greater impact on quality of care would result from a different type of preadmission review. We believe that this requirements lacks statutory basis.

Moreover, it would result in the performance of many unnecessary reviews and thus be a waste of scarce PRO resources. We believe strongly that physician-sponsored PROs should be given maximum flexibility to focus preadmission review on particular diagnoses, institutions, and practitioners that should be targeted based on local problems.

Contract Objectives

The AMA is particularly concerned over provisions exacted in PRO contracts that the contracts must establish objectives of reducing specified types of services, including admissions, by a specified amount. For example, a PRO contract may include an objective to reduce certain surgery admissions by 25%.

The AMA recognizes that PRO contract objectives are intended to be goals rather than quotas. Nonetheless, in practice these objectives may have the effect of encouraging an overzealous PRO to deny appropriate as well as inappropriate admissions in order to meet its contract objectives. We would be particularly concerned in the event that payor organizations are designated as PROs because these organizations have a long history of pursuing cost containment with less emphasis on quality of care. We ask this Committee to examine implementation of this program not only from the standpoint of reasonable time frames but also from the standpoint of the reasonableness of the contracting methodology and substantive objectives.

Evaluation Criteria

The AMA is concerned over a provision in the RFP that states that PROs will be evaluated based on changes in admission behavior in the PRO

area as well as on their ability to achieve specific contract objectives. The admission rate for the PRO area during the contract period will be compared to the admission rate before the contract went into effect.

PROs are mandated by law to deny inappropriate admissions. However, we believe that Congress did not intend that PROs be held responsible for changing the area's overall Medicare admission rates to meet arbitrary objectives. It is inappropriate to evaluate a PRO based on a function Congress did not intend it to perform. The danger is that the PRO is encouraged to deny more than the clearly inappropriate admissions.

Conclusion

The AMA strongly supports medical peer review that emphasizes quality assurance and continues to assist state medical societies in their efforts to become involved in the PRO program. In recent months, considerable progress has been made in the implementation of the PRO program. However, as discussed above a number of serious problems exist.

The AMA commends the Committee for this hearing and its interest in close oversight of PRO implementation. It is likely that this Committee's scrutiny has spurred the Department to act more expeditiously over the past six months. We urge you to continue to closely monitor the program to ensure that the concerns expressed above are adequately addressed. This is especially important in light of planned Congressional adjournment on October 4.

We are submitting statements and letters we have previously submitted to HCFA that explain our concerns in greater detail.

Mr. Chairman, the AMA appreciates the opportunity to testify here today. I will be happy to answer any questions Members of the Committee may have.

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JAMES H. SAMMONS, M.D.
Executive Vice President
(751-6200)

October 13, 1983

Allan Lazar
Director
Office of Professional Standards Review Organizations
Health Standards and Quality Bureau
Health Care Financing Administration
Department of Health and Human Services
1849 Gwynn Oak Avenue
Baltimore, Maryland 21207

Re: Scope of Work and Technical
Proposal Instructions and
Evaluation Criteria for the
Utilization and Quality Control
Peer Review Organization Program

Dear Mr. Lazar:

The AMA is pleased to submit its comments concerning the proposed "Scope of Work and Technical Proposal Instructions and Evaluation Criteria for the Utilization and Quality Control Peer Review Organization Program."

Sincerely,

James H. Sammons

James H. Sammons, M.D.

JHS/of
1103p

COMMENTS

of the

AMERICAN MEDICAL ASSOCIATION

to the

Health Care Financing Administration

RE: Scope of Work and Technical Proposal Instructions and Evaluation Criteria for the Utilization and Quality Control Peer Review Organization Program

October 13, 1983

The American Medical Association takes this opportunity to comment on the proposed Scope of Work and the Technical Proposal Instructions and Evaluation Criteria for the Utilization and Quality Control Peer Review Organization (PRO) program. The AMA has a number of serious concerns with the proposal, many of which relate to the proposal's undue emphasis on cost savings at the expense of quality assurance. The key provisions of the proposal and our comments concerning each are outlined below.

Comments

Quality of Care Objectives

The medical profession has a long history of involvement in quality assurance programs for health care. Many state and county medical societies were active in voluntary peer review before the enactment of the PSRO program. The primary goal of the medical profession in voluntary medical peer review is the improvement of care through the application of appropriate treatment modalities best suited to the individual patient

for his or her illness or injury, and through the creation of programs for the continuing improvement in medical education of physicians. Another important thrust of peer review should be the improvement and advancement of quality assurance programs and the application of the highest degree of technical expertise in the conduct of such review. The overriding objective of all such activities is to improve the quality of patient care.

The American Medical Association, while mindful of the need to constrain health care costs, supports medical peer review focused on quality of care, and to this end, has encouraged medical societies to become involved in the PRO program. Since the proposed Scope of Work emphasizes cost containment, the AMA believes that it should be amended to ensure that quality of care issues play the proper and prominent role in PRO activities. For example, the Scope of Work requires prospective PROs to establish admission control objectives in each of five specified areas for cost containment purposes. By contrast, bidders need include only one "quality objective" from among the following areas:

(1) Reducing unnecessary hospital readmissions resulting from poor care provided during the prior admissions.

(2) Assuring the provision of medical services which, when not performed, have significant potential for causing serious patient complications.

(3) Reducing avoidable deaths.

(4) Reducing unnecessary surgery or other invasive procedures with significant potential for causing serious patient complications.

(5) Reducing avoidable postoperative complications.

The AMA believes that the quality objectives could be strengthened by requiring bidders to establish specific objectives that address each of the five quality of care areas outlined above. Such a requirement would put bidders on notice that quality objectives are indeed as important as cost and admission objectives.

It is particularly important that the quality assurance function of PROs be strengthened and highlighted because of the new financial incentives for providers under the new medicare prospective payment system (PPS). Under the former retrospective cost-based reimbursement system, there was a financial incentive to provide services and, in some cases, to maximize the length of stay. As a result, one key function of PSROs has been to determine whether the services provided are medically necessary.

Under the PPS, hospitals will generally receive a predetermined amount per admission based on the patient's diagnosis. It is hoped that the PPS will encourage hospitals to provide the least costly treatment consistent with good medical practice. Nonetheless, the strong economic incentive for underprovision of services that is inherent in the PPS could pose a very real danger to patients and to continued high quality care. Hospitals may exert pressure on physicians to discharge patients or to withhold some medically desirable services. An implied threat that staff privileges could be affected could be used to attempt to coerce physician compliance.

In this new environment, PROs must play a vitally important role in ensuring that quality medical care is provided to the nation's elderly by supporting physicians in their decisions to provide medically necessary

care. Congress recognized the essential function of PROs as a safeguard for quality care under the new PPS by requiring hospitals to contract with a PRO in order to receive Medicare reimbursement.

The Scope of Work also provides that quality objectives would be measured in terms of the number of patients affected by the problem and the severity of the problem. Severity would be defined as the adverse effect of the problem on patients as determined by HCFA.

The AMA agrees that quality objectives should be measured in terms of the number of patients affected by the problem and the severity of the problem. However, we believe that HCFA should not have unfettered discretion in determining whether a problem is severe. Instead, contractors should be required to establish their quality goals and document the adverse effect of the problem on patients.

Performance Evaluation

The Scope of Work provides that a PRO's performance will be evaluated in terms of satisfying individual contract objectives and in terms of dollar benefits to the government compared to total contract costs.

The AMA believes contractors should be judged on the extent to which they meet their contract objectives. However, we are concerned that the Scope of Work appears to subordinate quality of care objectives simply because their dollar benefits would be difficult or impossible to calculate. The contract objectives that contractors are required to address are based on the four PRO functions specified in the Social Security Amendments of 1983: to review the validity of diagnostic information provided by hospitals, to review the completeness, adequacy and quality

of care provided, to review the appropriateness of admissions and discharges, and to review the appropriateness of care provided for outlier cases. Since Congress recognized the importance of the quality of care function, we believe that the Scope of Work should be amended to provide specifically that in evaluating a PRO's performance, quality of care objectives will be accorded equal weight with cost and admission review objectives, DRG validation objectives and outlier review objectives.

The AHA vigorously opposes evaluating a PRO based on a cost-benefit ratio. Section 1153(c)(2) of the Social Security Act provides that "the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract." We believe that the functions specified in the PRO contract should be based on the four functions enumerated in the Social Security Amendments of 1983. Since no mention is made in the Social Security Amendments that saving money for the government is a PRO function, it would be improper to judge a PRO based on a cost-benefit ratio.

The Scope of Work also provides that a PRO will be evaluated in part on an "admission factor" based on gross admissions in the PRO area. The admission factor will be calculated by comparing the rate of increase or decrease in the admission rate for the PRO area during the contract period to the increase or decrease in the admission rate before the contract went into effect. If the average admission rate for the PRO area in the four years preceding the contract period is below the national average, the contractor's target rate will be the PRO area

rate. However, for PRO areas in which admission rates have been falling, the contractor's target rate will "be a zero percent change." If the average admission rate for the PRO area in the preceding four years is above the national average, the contractor's target rate will be the rate halfway between the PRO area rate and the national average. Changes in actual admission rates during the contract period will be compared to the contractor's target rate. Changes that are above the target will be calculated as a negative benefit. A rate that is below the target will be credited to the contractor as a positive benefit.

The AMA opposes the use of an admission factor in evaluating a PRO's performance. Not only is there no statutory basis for utilizing an admission factor, but there is no data to show that a "national average" -- a mere mathematical calculation -- represents an appropriate level of admissions. One of the functions of a PRO is to review the appropriateness of admissions and discharges -- not to arrive at a nationally determined quota. Congress did not make PROs responsible for changing the area's overall Medicare admission rates to conform to a national standard. Thus it would be inappropriate to evaluate a PRO based on a function which Congress did not intend it to perform, particularly when the criteria proposed are arbitrary and not based on proper quality considerations. It should be pointed out that national averages do not make allowances for local factors such as variations in population age and catastrophic events.

Evaluation Criteria

The proposal specifies a point system for evaluating the various contract bids. A maximum total of 1000 points is possible (1,100 for physician organizations). The evaluation criteria carrying the most number of points are the quality of the personnel managing the PRO and reviewing care (200 points), admission objectives (185 points), quality objectives (185 points), experience (150 points), and data collection and analysis (100 points).

The AMA has three major concerns with the point system for evaluating PRO bids. One concern is that the point system fails to establish objective standards for HCFA to use in determining how many points a prospective contractor should be awarded for each evaluation criteria. For example, it is not clear whether a bidder who establishes an objective of reducing inappropriate admissions by 20% will receive more points than one who sets an objective of reducing inappropriate admissions by 10%. The result is that HCFA is given excessive authority in awarding points. The AMA believes that objective criteria for awarding points should be clearly specified so that HCFA is not allowed virtually unfettered discretion and bidders are aware of the basis on which they will be evaluated.

Our second concern involves the awarding of 150 points based on an applicant's experience. A maximum of 50 points would be assigned based on the number of years an applicant had been conducting review activities. Another 50 points would be assigned based on whether an applicant had private review or Medicaid review experience. Only 50 of the points relating to experience would be based on the quality of the organization's previous review activities.

In our view, length of review experience and the number of review contracts held by an applicant are irrelevant without taking into account the quality of the applicant's review. For example, an applicant could obtain 50 points for having private review contracts and Medicaid contracts without any measure as to the quality of review activity. The quality of the applicant's review could be minimal or even substandard. However, points would be assigned based solely on the existence of those contracts. Likewise, length of experience fails to recognize that an applicant could have been a minimal performer and had managed to retain review activity for the requisite number of years.

We suggest, instead, that previous experience only be considered in conjunction with the quality of that experience. We also believe that only 100 points should be assigned to this item. An overemphasis on experience could preclude selection of a new organization that, through innovative approaches, could provide greatly enhanced review activities.

Our final concern relates to the awarding of 100 bonus points for physician-sponsored organizations. The AMA believes that the awarding of a mere 100 bonus points (only 10% of the total) for "physician-sponsored organizations" fails to satisfy the statutory mandate that such organizations be accorded "priority" over "physician-access organizations." "Priority" denotes a preference of one party over another in the exercise of rights over the same subject matter. In order to assure that physician-sponsored organizations receive the preferred status that Congress clearly intended, HCFA should establish a different method for evaluating the proposal of a physician-sponsored organization if it is competing

against a physician-access organization. We recommend that HCFA establish a policy whereby a physician-sponsored organization will be awarded the contract over any physician-access organization that submits a bid as long as the physician-sponsored organization receives a specified minimum number of points. The fact that a physician-access organization may accumulate more points would be irrelevant. The number of points that a physician-sponsored organization would need to amass would be the minimum number required to ensure that the organization is qualified to be a PRO.

Admission Objectives

The Scope of Work provides that contractors must develop admission objectives in each of the following five areas:

1) Reducing inappropriate admissions.

2) Reducing the number of admissions for procedures usually performed on an outpatient basis.

3) Reducing the number of admissions for unnecessary invasive procedures.

4) Reducing the number of inappropriate transfers to PPS-exempt psychiatric and rehabilitation hospitals or units, and swing beds.

5) Performing Admission Pattern Monitoring.

Contractors may establish additional admission objectives in the following areas:

1) Reducing overall admissions.

2) Reducing admissions for specific diagnosis related groups (DRGs).

3) Reducing admissions for specific practitioners or providers.

The AMA agrees that contractors should be required to establish admission objectives for the five mandatory areas. Congress specifically stated that one of the functions of a PRO under the PPS is to review "the appropriateness of admissions and discharges." All of the five areas relate directly to the function of reviewing the appropriateness of admissions and discharges.

We are extremely concerned, however, over the sample calculations in Attachment 5 concerning how to compute a contractor's cost-to-benefit ratio because they indicate that PROs will be permitted to establish admission objectives of reducing the total number of admissions in their area for a particular diagnosis. The Scope of Work, for example, suggests that a contractor may establish an admission objective of reducing the number of admissions for pneumonia by 20%. The AMA strenuously opposes the setting of arbitrary standards by which performance is measured. PROs could be encouraged to deny appropriate as well as inappropriate admissions in order to meet their contract objectives. The likely result would be rationing or denial of health care for the nation's elderly.

The AMA also believes that to allow contractors to establish admission objectives of reducing overall admissions, admissions for specific DRGs or for specific practitioners or providers would go well beyond Congressional intent. No language in the statute or the conference report can be found to indicate that Congress viewed PROs as a mechanism for reducing overall admissions for Medicare patients irrespective of the need for the admission. In addition, a PRO could reduce overall admissions, admissions for specific DRGs, and admissions for specific practitioners or providers in its area without successfully performing their

function of preventing inappropriate admissions. The objectives should relate to reducing inappropriate admissions for specific DRGs and inappropriate admissions for specific practitioners or providers.

Peer Review

The Scope of Work states that PRO contractors would be required to utilize physicians to review the care provided by other physicians. The Scope of Work also provides that in making reconsideration determinations, a PRO would be required to utilize board certified or board eligible physicians or dentists in the appropriate specialty.

The AMA believes the Scope of Work should be amended to clearly provide that only doctors of medicine and osteopathy are authorized to review the care provided by other such doctors. Dentists should be restricted to reviewing services performed by other dentists. We also believe the Scope of Work should be modified to require that in making reconsideration decisions, PROs must utilize "qualified physicians with appropriate expertise." One of many ways of determining whether a physician is qualified in a specialty is board certification. However, the term "board eligible physician" is no longer generally recognized as denoting that a physician is qualified in a particular specialty.

Time Periods

The Scope of Work provides that within 45 days after the contract is effective, the contractor must submit a brief description of its written criteria for conducting utilization review and quality review. By that time the contractor must also have executed a Memorandum of Understanding (MOU) with each fiscal intermediary (FI) in the area, have commenced

collecting and entering data into the monitoring system and be capable of developing patient profiles, physician profiles, hospital profiles, DRG profiles and diagnosis/procedure profiles.

The AMA believes these time frames may be insufficient for prospective contractors to complete the necessary tasks. As a result, we urge HCFA to lengthen these time periods to 90 days.

Conclusion

The AMA supports medical peer review focused on quality of care. Thus, we want to ensure that the PRO program does not repeat the PSRO program's mistake of becoming devoted primarily to the purpose of restricting health care expenditures. We believe strongly that the Scope of Work and the Technical Proposal Instructions and Evaluation Criteria should be modified as noted above to help ensure that the PRO program emphasizes quality assurance as well as cost containment.

1103p

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JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

March 30, 1984

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration
Room 314G Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: PRO Program

Dear Dr. Davis:

As you know, the American Medical Association has actively supported the efforts of state medical associations seeking designation as Peer Review Organizations (PROs) under the Utilization and Quality Control Peer Review Organization program, and we anticipate a significant number of state medical associations will respond to the PRO Request for Proposal (RFP).

The AMA is very interested in seeing a successful PRO program as intended by the Congress. We know that you, too, want the program to be successful. Therefore, we hope you will share our serious concerns with the current direction of implementation through the RFP process on several very significant aspects of the program. We believe that these problems can be addressed at the administrative level. As the April 27, 1984 deadline for responding to the RFP is rapidly approaching, we urge your consideration of our suggestions herein at the earliest possible time. If it is necessary, as we think it will be, to provide a brief extension (e.g. 15 days) past the April 27th deadline in order to accomplish our suggested changes, we believe that such extension would be to the benefit of the program and should be effected by your office.

Two major areas of the Request For Proposal (RFP) for the PRO contracts are of concern. Briefly, these are:

- Inflexibility of the fixed-price total compensation approach in establishing financial terms of the contracts; and the

- Extent and inflexibility of the preadmission and pre-procedure review requirements.

In regard to the first point, we recognize that the PRO should assume some degree of financial risk under the program, and that this is consistent with congressional intent. The RFP, however, requires that a single total amount be fixed to cover the full

period of the contract, regardless of the fact that many of the services required to be performed are highly variable and not under the control of the PRO. In fact, certain required tasks relating to the prospective pricing system under Medicare, such as outlier review and admission pattern monitoring, have not been widely performed in the past, thus there is little experience with such activities.

Thus, as proposed in the RFP, the two-year fixed-price contract could create undue financial hardship and substantial risk. For example, the cost of reviewing outliers over the course of the two years might be significantly above an original estimate and substantially exceed the amount of funds projected for the service under the contract, with such funds being expended prior to expiration of the two years. While the obligation to perform reviews for the remaining portion of the two-year contract would continue, there would be no additional funds under the contract. This could result in undue exposure of assets of the entity applying to be the PRO and may even place in jeopardy the very existence of the entity that had become a PRO in good faith seeking to accomplish the program objectives.

We do not suggest the establishment of "a cost-plus" contract. We recognize the legitimate desire to hold down PRO costs. We are certain that physician-composed PRO's will seek to meet their appropriate review responsibilities consistent with quality of care objectives.

We suggest that one approach that would strike a reasonable balance as an alternative to the current strict approach of a fixed-price total compensation two-year contract would be to provide for renegotiation of the contract based on actual experience after one year.

In regard to the second major point, the mandate that was administratively created through the RFP process, that all PRO's perform preadmission authorization review in five of the twenty most prevalent DRG categories, is an unacceptably inflexible approach to pre-admission review that does not assure accomplishment of the program goals.

We support focused preadmission review by physician PRO's. We do not believe that either the wording or intent of the PRO statute justifies requiring all PRO's to perform preadmission review in at least five of twenty designated DRG categories. This is an arbitrary approach which will burden PRO's, create unnecessary reviews, and interfere with the timely delivery of medical care. Again, we support physician PRO's doing focused preadmission review. However, in requiring PRO's to meet agreed upon objectives, the PRO's must be given the flexibility of achieving these goals based on local needs.

We strongly urge that expeditious administrative action be taken to incorporate the above requested modifications in the RFP process. No changes in the statute are necessary to accomplish these modifications.

The AMA is interested in seeing a successful PRO program as intended by the Congress, and we believe that the requested changes are necessary to accomplish this goal.

Finally, we would like to comment on the March 19, 1984 "Pre-Proposal Conference" in Baltimore sponsored by HCFA. The stated purpose of the Conference was to "provide information concerning the government's requirements which may be helpful in the preparation of proposals, and to answer any questions which prospective offerors may have regarding this solicitation" for PRO contract proposals. During the Conference numerous questions concerning the business proposal for the RFP, access to data, PRO relationships with area hospitals, and confidentiality of data were raised. Unfortunately, most of the questions were unanswered.

With approximately four weeks remaining to respond to the RFP (April 27, 1984), bidders have not yet received answers to essential questions posed at the Conference on March 19, 1984. Accordingly, we are very concerned with the lack of direction HCFA is providing in implementing this important program, and, therefore, request your intervention. We believe that some brief extension past the April 27th deadline is justified to provide changes relating to the major concerns we have raised and also to provide answers to the questions raised at the conference.

We thank you for the serious consideration we know you will give to the matters we have raised in this letter.

Sincerely,

James H. Sammons, M.D.

JHS/dm

0567p

AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 645-5000 • TWX 910-221-0300

JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

April 6, 1984

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration
Room 314G
Humbert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: PRO Program

Dear Dr. Davis:

Thank you for your prompt response to our March 30th letter to you regarding our concerns about the implementation of the PRO program. We appreciate your desire to be responsive to these concerns. Unfortunately, your letter has not resolved them.

In response to our concern over the inflexibility of the fixed-price total compensation approach set forth in the RFP, your letter states that the contract may be adjusted based on certain factors and that while only HCFA is empowered to initiate such changes, PRO's could suggest the need for such a change. Your letter states that this approach will allow HCFA to be responsive should circumstances for the PRO change significantly.

While PRO's will have an opportunity to request a renegotiation of the contract, we believe and had suggested that some explicit right in this regard should be incorporated into the contract. Under the approach you describe, PRO's will not have such a right, and it will be entirely within HCFA's discretion to decide whether any alterations will be even considered. We note further that the answers to questions on this issue set forth in the transcript of the Preproposal Conference, while not entirely consistant, indicate the contracts will not be reopened and prices will not be renegotiated (we refer to pages 48, 49, 52, 53, 56, 57 and 95 of the transcript and to page 3 of the supplemental material to the transcript). These answers are indeed disturbing.

In regard to the preadmission and preprocedure review points raised in our March 30th letter, your letter states that the PRO offeror may select DRG's from the list of the most prevalent DRG's in the individual PRO area. However, under the RFP the PRO's are, in fact, required to select five of the twenty most prevalent surgical procedures for preadmission review and to review all cases within each classification. The only exception to this requirement is if the PRO proposes to review other than the most prevalent DRG's, in which case it must document the greater cost benefit of such review or the greater potential for impact on the quality of care. The point remains that the PRO is required to perform preadmission review in five DRG's, rather than being authorized but not required to perform such preadmission review. Desirable PRO flexibility in meeting its contract obligations is not existent under this approach. As indicated in our prior letter, we do support focused preadmission review by physician PRO's. Such PRO's should be allowed to determine for themselves which, if any, particular diagnoses, institutions or practitioners should be targeted for focused preadmission review.

We trust this letter will receive your earliest consideration. Again, let me express our appreciation for your cooperation. If we have misinterpreted your letter, we would appreciate hearing from you or meeting with you in order to obtain essential clarification on these issues.

Sincerely,

James H. Sammons, M.D.

JHS/dm

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Senator DURENBERGER. OK. Thank you very much, Dr. Nelson. Jack, let me ask you what the experience has been around the country, and I think one of the things that has come through in this hearing is that both with regard to the so-called objectives or quotas—for example, to use your analogy, it may look like a fish and a lot of people think it swims like a fish, but it doesn't smell yet——[Laughter.]

But one of the things I want to make sure of is that we don't get to that stage. By the same token, as you look around the country at the peer review, if we have made the commitment now to go State by State to implement these changes, as Dr. Nelson has just pointed out to us, these contractors may look like peer review organizations and they may even swim like them, but some of them are going to start to smell if they don't have the professional skills, if they don't have in that area an adequate data base. And obviously, this is a question that I want Carolyne Davis to respond to in terms of the variety that she anticipates around the country. But that is clearly also going to have an impact on the hospitals around this country, if there hasn't been a familiarity in some areas working with professional review organizations. If there are the problems that you talked about in terms of data base, I am just curious to know where the interrelationship between hospitals and peer review organizations has worked well and where it has not and what we might learn from that. I know your statement talks about how the regs came out very late with only 30-day comment periods and so forth. But I assume that in some parts of the country we will find that not to be a big problem. In other parts of the country, in other kinds of institutions perhaps, it will be a problem, and maybe you can focus some advice for us on the areas in which hospital involvement needs to be improved upon in some way.

Mr. OWEN. OK. Let me try. I think that you are right. There are some differences and it stems back primarily from the standpoint of how effective a PSRO was before we got into this system. I think this was pointed out by Dr. Nelson. But the problems that I am hearing as I go around the country are things such as the removal of the waiver of liability, which I touched on—this change in the way that this is occurring. And what this basically means is that before a hospital can go to a patient for payment, they must have a favorable presumption, and in order to do that—to get that favorable presumption—it is the PRO who must prove that they are not doing things right now. The switch in this burden of proof really is now that the hospital must always prove, and when you went from 2.5 percent of the total patient days to 2.5 percent of those who were reviewed, you almost wiped out all the hospitals in that kind of a presumption. There is a lot of concern about how they are going to continue in that particular role, and the cash flow problems that go with it.

That is one of the big ones coming out. The other big one coming up has to do with the amount of review that is taking place because of this by sending these medical records. And I think Dr. Weeks touched on it a little bit, but I have gotten reports—reliable reports—that they are stacking up in boxes in some PRO offices around the country, and they just are so big that it takes so much time to get through them that they don't know what to do with

them, and yet that delay holds up what the hospitals are doing in the cash flow. So, there is a great concern about that—concern about the confidentiality that goes along with that, and with the costs, although we recognize that the cost of the PRO Program was part of the DRG prospective payment system, but none of us I think realized that we were going to have to do as much copying of records and that kind of thing. The real problems that we are seeing now--the so-called objectives—the targets that the PRO's are now going for—have not really hit the hospitals fully yet because many of them don't even know that they are on the list on which a so-called target has been called and which you, Mr. Hospital in Louisville, KY, or Atlanta, GA, are going to have to have a reduction of such and such by that diagnosis or what have you.

In some of the cases, the hospitals themselves don't know that the PRO had done this, and that is going to create a big flack. I am sure you are going to hear about that in the next few months unless there is more communications between the hospitals, PRO's, and the HCFA. In some cases, I am hearing real problems on this so-called 4 or 5 to 1 ratio of which the PRO must generate a certain amount of savings in order to be continued as a contracting agency. That has created some real problems from the standpoint of where the PRO has taken a position—well, HCFA is making us do this, and therefore we have got to do it, and you don't have any choice. We have even had some hospitals who have complained because PRO's in particular said if you want to contract with me in November, you have got to let me review all your patients, not just medicare. And I talked to Carolyne about that, and she has written a letter saying that that is not in the game, and she has been very helpful when these specific things have been brought up. But that kind of feeling between the PRO—who is out there—and HCFA here and the hospital here, of using one side or the other, seems to be growing, and I am quite concerned about it. Quality has become lost in the whole process. That is what we are concerned about.

Senator DURENBERGER. It has or it will?

Mr. OWEN. I think it is becoming, yes. Definitely. We are not talking about the quality of what is going on. We keep talking about how we are going to be saving money, and how we are going to meet our objectives. And objectives are measured by money savings.

Senator DURENBERGER. Is that a statement on behalf of the American Hospital Association—that they are not talking about quality any more?

Mr. OWEN. Oh, no. I said the statement is not on the American hospitals. We are very concerned about the quality. We are concerned that the PRO's are less concerned about quality, and that is why we were supporting PRO's—it was for a quality assurance that, when you are in the hospital, the patient has a reasonable assurance that there is an outside agency that has looked over it and seen that the quality is good. We think it should be done on an audited basis—the same way that accounting firms audit businesses. It doesn't have to be on every single case. When you find somebody who is misusing or abusing the system, they ought to clamp down hard on them. I have no sympathy for those—the hospitals or phy-

sicians. But I do think that going after all hospitals and all physicians is getting a little bit much.

Senator DURENBERGER. All right. I think I am about to have a large problem here, so let me thank both of you for your testimony. And Alan, thank you in particular for coming out from Utah. Now, let me ask Dr. Davis to come back and perhaps summarize. I have made a few notes and I am sure you have to—to reactions of the various witnesses and perhaps if you would just work right off of what you have.

Dr. DAVIS. Let me rapidly move through my list of notes here. First of all, Dr. Dehn said that he was concerned that when we had a 100-percent administrative review that they would have to review all cases in a specific hospital. That is not true. The Peer Review Organization can make a determination that, if it is one specific physician, then they can focus on just that one physician or one or two or whichever. They do have the ability to target to specific persons if they believe that they are the ones that have been having significant deviations in practice patterns as related to the intensified review.

Senator DURENBERGER. But 2.5 percent is still the cliff?

Dr. DAVIS. Yes, and I would like to come back to that in a moment here. I am afraid if I go out of sequence, I am not going to cover all these things. There was a concern expressed relative to the prescriptive method of conducting the reviews. I think we have tried to follow guidelines, but we have been under Federal procurement guidelines so that we must conduct our discussions in certain ways because it is a competitive contract. That is why we attempted to be fairly prescriptive in relationship to what we wanted. And, second, the prescriptiveness on pages 5, 6, 7, and 8, I believe, dealt with the whole issue of the mandated reviews under prospective payment systems. As you know, when we implemented that system, we were quite concerned that there might be a possibility for inappropriate utilization activities that would relate to bringing an admission back too soon—or not bringing an admission back to soon but just readmitting, in other words, to gain maximum reimbursement. So, we indicated that for the initial target time, we wanted to do a very large sample review. In the initial peer review material, we just repeated what we had said in the prospective payment regulations: that we would want to do medical review on all the admissions within 7 days; all transfers; selected DRG's like the pacemaker; outliers; and then a certain percent of random admissions. The issue of outliers was brought up, and I think we, too, are looking at that. It has been our intent to move aggressively in our monitoring under the mandated review during the first year of the prospective payment system because I am a firm believer that if you can institute good habits of behavior to begin with, we then don't have to move back and take corrective actions at a later point. So, we have determined that we probably don't need to review 100 percent of the outliers, but there is something to be said for the sentinel effect. I think we will probably discuss in our own group what percentage might be appropriate, so we are prepared to look at that. Concerning the issue of asking the Peer Review Organization to review outpatient services. I have asked my staff to prepare a report to me by December 1985 that would look at the advis-

ability of doing that. What we want to do first is look to see how well we are able to implement the system of review for the inpatient hospital component, and then make a determination as to the relevance of expanding to outpatient review also.

The issue that Dr. Weeks spoke about regarding–oh, I have already covered that. The loss of favorable presumption simply means that if one loses that favorable presumption, one then goes in to the next quarter with a more intensified review, and then one reviews case by case to determine where liability lies. All we are saying is that we think that if a hospital has had a 2.5-percent number of cases that were inappropriate admissions, then we ought not to continue to allow that. And we think that it is an effective tool to say to the hospital, look, during this period of time that just passed, you had *x* number of cases that were inappropriate admissions. We paid for every one of those. Now, during this next quarter, we are going to put you on a case-by-case review in order to help you to educate your people so that we don't continue to have that same kind of ongoing. inappropriate activity. We don't have that many on an intensified review, and we can submit to you for the record on the basis of our first year of admission pattern monitoring how many we have had that have moved to that area. But I regard it as an educational mandate to allow them to earn their way back off in the next quarter. It is true that during the next quarter they have to show that they have 97.5 percent appropriate admissions, but, again, I think we are all trying to have only appropriate admissions. On the issue of the PRO's sending back just a statement saying payment denied, we don't allow that. If individuals have had that happen and they provide us with the detail of where it has happened, we will go back and educate our contractors. It has been very clearly stated in the conduct of review regulations that before a physician can have a payment denied, two things must happen. First, before the PRO can make a denial, a physician must actually review the case and decide that it is appropriate for denial. Second, the physician must then contact the attending physician and discuss with him—it may not necessarily be face to face—the case.

Senator DURENBERGER. Was that your past practice as well as your new practice, because it is apparently happening all over my State.

Dr. DAVIS. Yes.

Mr. NATHANSON. Yes, that has been our practice.

Senator DURENBERGER. It has? OK.

Dr. DAVIS. Dr. Nelson advocated that the State medical societies be involved in either the contract negotiations and/or awards or the support, and I think they clearly have been. I noted that our statistics would indicate that out of the 26 that we have awarded already, I believe that for all but 6 of them we have had formal notification of medical association support in writing as a part of the proposals. We would continue to expect the State medical societies to be active in this particular area. In fact, before we sent formal notice to the first 15, I picked up the phone and called Dr. Sammons to alert him to the fact that we were concerned. We wanted to have medical review, contrary to what some people's

opinions are, and I wanted to continue to encourage their working with us to sort out these particular problems.

Speaking of sorting out these particular problems, as I listened, I think I can offer perhaps two suggestions here. It does seem like there has been a lack of total open communications in a triparte system here. And perhaps I can use my office to call together a representative group that represents the hospitals, the Peer Review Organizations, and ourselves to sit down and begin a series of discussions. Likewise, I would observe that we do have a hot line that we have kept open during this first year of prospective payment implementation, and I have just discussed with the staff here whether we needed a separate hot line for implementation of Peer Review Organizations. I don't believe we do, but I would say this: We will use that hot line for the Peer Review Organizations. So, if there are problems that crop up individually, the hospitals do have the hot line number and I would encourage them to use the hot line to alert us to those particular problems.

And finally, I would like to clarify one other point. Jack Owen indicated that he had a concern that related to the idea of a ratio of $4 to $5 savings for every dollar spent by a pro. I am thinking they have gotten confused with some of our instructions to our fiscal intermediaries that looked at that kind of a ratio. I don't know of anything that has been sent to the Peer Review Organizations.

Mr. NATHANSON. That is right. There is no such ratio.

Dr. DAVIS. I just wanted to clarify that for the record. I think that I have mentioned most of my points. Let me ask Mr. Nathanson if he has something more to add.

Mr. NATHANSON. Not really. The only comment I wanted to make was—two comments. One has to do with the concept of overzealous Peer Review Organizations having to meet their objectives by denying care inappropriately. We feel that it is an extremely important part of our oversight that we work with the PRO's and make sure that they and we don't get in any such position. We are going to be evaluating the PRO's independently as to their appropriateness and necessity judgments and as to the way they do their business according to the objectives, as you requested us to do. We will know when Peer Review Organizations have trouble with their objectives as soon as they do. And we intend to be active there. We are not going to wait for them to tell us that they are having a problem, and what do I do now? We are going to be working with them on that. We are going to have an independent medical review group which is not a PRO—an independent medical peer review group helping us evaluate the appropriateness of PRO necessity and appropriateness decisions. We will be making sure that they do not too aggressively deny care that is needed, as well as making sure that they are firm in their review.

I guess I have just one more comment I wanted to make.

Senator DURENBERGER. Will you make it short?

Mr. NATHANSON. Yes; it is about communication. We certainly have made contracts available to everybody and will continue to do so. So, hospitals shouldn't be surprised if they are on the list.

Senator DURENBERGER. Let me just summarize this. I think the most progress we have made today is discussing the negotiable

target concept. And if you keep that in mind, and if everybody tries to keep that in mind and forget the fact that you are running a bureaucracy, and it is hard for us to do that sometimes, but try to keep your best of intentions in mind—that is a major step in the right direction. I think also that one of the things we all need to understand is this whole issue that we have not had stability in peer review in this country since it started. And now that the Hospital Association supports it and the AMA supports it and a whole lot of other people are supporting it, maybe we have the opportunity for that stability. And with that stability will come the confidence that ought to exist between the hospital and physicians and the other provider community and those folks—their colleagues in effect—who have to participate in this process. And we have to count on that being realistic. And the other thing I shouldn't have to restate is how much we have at stake in making this thing work and I said to all of you this same thing privately and publicly, but medicare is a big insurance company run by 535 politicians, none of whom show up for these meetings. [Laughter.]

And the sooner we get out of the insurance business, the better. You know, this is a part of that process, whether you guys who depend on it for livelihood like it or not—this is a part of that process. So, I think we will all be back here next week to deal with an extremely important subject, with which we are all involved, and I hope all of you can approach it with the same positive nature that you did today. And we will see you all next week. The hearing is adjourned.

[Senator Long's prepared written questions follow:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

NOV 19 1984

The Honorable Russell B. Long
United States Senate
Washington, D.C. 20510

Dear Senator Long:

Enclosed are the responses to questions you requested Dr. Carolyne K. Davis, Administrator, submit for the record of the July 31 hearing on the implementation of the Peer Review Organization program.

Sincerely yours,

Carol A. Kelly
Director
Office of Legislation and Policy

Enclosure

Q. How will determination of the appropriateness of a hospital admission and plan of care be made?

A. Cases will be reviewed by PROs in accordance with locally established physician criteria. For cases not conforming with the criteria, the case is referred for review to a physician usually of the same specialty. Before a physician denies a case on the basis of failing to be medically necessary or appropriate, he/she must attempt to contact the attending physician to discuss the case. The beneficiary, attending physician, and the hospital have the right to request a reconsideration of a denied case.

Q. How does HCFA set targets for reduced utilization in specific DRGs? Is there a mechanism to adjust these targets should experience show them to be unrealistic?

A. HCFA does not set targets. The targets are negotiated with the PRO bidder and must be identified and valid using available data. Validation could be actual case review or the use of published studies. Where possible, HCFA required that the validation be specific to the PRO area.

Where PRO experience demonstrates that the targets are unrealistic, the objectives and targets can be renegotiated, provided that the request for modification is justifiable. Furthermore, where such modification significantly diminishes the impact or work performed under the contract, HCFA may require a substitute objective.

[Whereupon, at 3:33 p.m., the hearing was adjourned.]

[By direction of the chairman the following communications were made a part of the hearing record:]

ASIM TODAY

STATEMENT OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE SENATE FINANCE COMMITTEE

FOR THE RECORD OF THE HEARING ON

IMPLEMENTATION OF THE UTILIZATION AND QUALITY CONTROL

PEER REVIEW ORGANIZATION (PRO) PROGRAM

JULY 31, 1984

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american society of internal medicine
1101 VERMONT AVENUE NW-SUITE 500
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STATEMENT OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE SENATE FINANCE COMMITTEE

FOR THE RECORD OF THE HEARING ON

IMPLEMENTATION OF THE UTILIZATION AND QUALITY CONTROL

PEER REVIEW ORGANIZATION (PRO) PROGRAM

JULY 31, 1984

The American Society of Internal Medicine (ASIM), an organization representing more than 18,000 physicians who are specialists in internal medicine, takes this opportunity to offer its views on the implementation of the peer review organization (PRO) program.

ASIM has spent considerable time studying, evaluating, and promoting physician-directed peer review for the last 20 years. The Society has urged its members to serve on utilization review committees of medical societies and hospitals; has testified, both orally and in writing, before congressional committees; has contracted with HCFA to study methodologies for assessing quality medical care; has commented on regulations implementing the PRO program; and continues to assist and encourage members to take an active role in the development of PROs in their states.

The Society commends the Committee for its close oversight of PRO implementation. We are especially pleased that Congress has extended the period of preferential treatment for physician-sponsored and physician-access

organizations from October 1, 1984 to November 15, 1984. Extension of this deadline will help further assure that physicians--not fiscal intermediaries--will be responsible for ensuring that quality of care is maintained under the prospective pricing system.

Despite the extension of the deadline by which hospitals must contract with PROs, ASIM has some concerns about the progress of the PRO program. To date, HCFA has published only one final rule. This rule deals with the issues of PRO area designation and the definition of eligible organizations. Several other rules have been proposed. The most recent proposed rule was published July 17; comments on this rule are due August 16. ASIM urges the Committee to monitor the development and publication of final rules by HCFA to ensure that the program is fully implemented by the November 15th deadline.

ASIM is also concerned that HCFA's slow pace in awarding PRO contracts could result in some hospitals not having contracts with PROs in their area by November 15. If hospitals have not contracted with a PRO by this date, they will be denied Medicare reimbursement. To date, only 30 organizations have been awarded contracts. These organizations only now may begin the potentially lengthy process of contracting with area hospitals. Unless PRO contracts are signed in the remaining states in the very near future, those organizations may find it difficult to complete contract negotiations with hospitals by the November 15 deadline.

Similarly, if a physician-directed or physician-access PRO is not designated by November 15, 1984, then fiscal intermediaries--who up to that point could not be considered--would have the chance to compete for contracts. ASIM

believes that review responsibilities should properly rest with physicians not fiscal intermediaries. It is likely that there would be less emphasis put on quality of care and more placed on cost reduction under review by fiscal intermediaries. Under the prospective pricing system, PROs are one of the few mechanisms to assure that patients will receive quality care. The diagnosis related group (DRG) categorization creates incentives for hospitals to (1) prematurely release patients to keep the cost of treatment and length of stay down; (2) provide inadequate services to increase profits; and (3) refuse treatment of cases that may be less financially rewarding given the allowed payment for that DRG. Consequently, it is essential that physician-directed PROs be in place to protect patients from the potentially adverse effects of the DRG system.

For these reasons, ASIM urges Congress to extend the contracting deadline once again, if necessary, to assure that hospitals won't be denied Medicare reimbursement and that physician-directed PROs will be in place to review services provided to Medicare beneficiaries.

ASIM is also strongly concerned that HCFA is placing inappropriate emphasis on requiring PROs to reduce admissions by specified amounts in order to obtain a review contract. If prospective PROs conclude that a commitment to drastically reduce hosptial admissions is a prerequisite for obtaining a review contract, the result is likely to be the inclusion of admissions objectives that are inappropriate and unrealistic for the community being served.

ASIM recognizes that PRO contract objectives are intended as goals or benchmarks for evaluating PRO performance, rather than rigid quotas. However, since such admission objectives will serve as one important factor in evaluating PRO performance, PROs may feel compelled to do everything possible to reduce admissions by the amount specified in the contract--even to the point of denying appropriate as well as inappropriate admissions in order to meet the objectives. This will be less of a potential problem if the initial admissions objectives established by the PRO and HCFA are reasonable. However, as noted previously, prospective PROs may be establishing unreasonable objectives solely to obtain a contract from HCFA. ASIM is particularly concerned that if fiscal intermediaries are designated as PROs (in the absence of a contract being awarded to a physican-directed or physician-access PROs), such organizations are likely to emphasize denying admissions to meet strict admissions objectives--with a potential adverse effect on the quality of patient care.

For these reasons, ASIM urges the Committee to monitor HCFA's performance in awarding PRO contracts, to assure that undue pressure is not being placed on prospective PROs to come forth with unreasonable or rigid admissions reduction objectives.

In conclusion, ASIM strongly supports peer review that emphasizes quality of care over cost savings. Practicing physicians are best qualified to review their peers and assure that only necessary and high quality services are provided under the prospective pricing system.

We urge you to continue to closely monitor the PRO program to ensure that the concerns outlined above are addressed.

STATEMENT OF THE

FEDERATION OF AMERICAN HOSPITALS

SUBMITTED FOR THE RECORD ON THE

IMPLEMENTATION OF THE PEER REVIEW ORGANIZATION PROGRAM

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

JULY 31, 1984

The Federation of American Hospitals is the national association of investor-owned hospitals representing over 1,000 hospitals with over 120,000 beds. Our member hospital management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

We appreciate this opportunity to present our views on the implementation of the Peer Review Organization (PRO) program. The Federation has always been a strong advocate of medical peer review at the hospital level to assure not only the quality of patient care, but also to eliminate or to minimize medically unnecessary admissions; medically unjustifiable lengths of stay; and modes of treatment or performance of procedures that do not contribute to the well being of the patient.

The Federation believes that the Peer Review Organization program, as developed by Senator Durenberger and enacted into law two years ago, represents a vast improvement of its predecessor, the Professional Standards Review Organization (PSRO) program created by the Medicare Amendments of 1972. The PSRO program as implemented through the regulatory process became an inflexible and complex system of federal standards, with criteria and norms that proved to be so expensive, unworkable, and uncontrollable that both the Executive branch and Congress were willing to let it expire. Alternatively, the PRO program, at least in its legislative language and Congressional intent, appears to improve the medical review process by allowing greater flexibility at the local level and less direct federal control.

However, the proposed regulations issued by the Department of Health and Human Services (DHHS) implementing the program and the PRO contracts recently awarded lead us to believe that

we again will have a rigid, arbitrariy and unworkable peer review system based on cost savings to the Medicare program.

We are most concerned about the objectives being set for professional review organizations to reduce Medicare hospital admissions and the lack of opportunity for public comment in the development of those objectives.

The primary focus of the program should be quality review, not cost savings. However, the Scope of Work released by the Health Care Financing Administration (HCFA) as the basis for PRO contracts and examination of several contracts subsequently awarded, demonstrate that savings to the Medicare program will take precedence in awarding and renewing PRO contracts and measuring the efficiency of a PRO.

The implementation by HCFA of the legislation authored by Chairman Durenberger amounts to the establishment of a quota system for hospital care and will limit access to medical services by Medicare beneficiaries. Use of national data with no input by the parties most directly affected -- hospitals, physicians, beneficiaries, and local PROs -- makes it difficult to envision this program as currently implemented as having any long term beneficial effects. Quality and appropriateness of medical care cannot be measured by strict federal standards based on national averages. Such a system cannot constitute

effective peer review.

The Federation does not object to the use of flexible standards for determining appropriateness of medical care. However, we do object to establishment of arbitrary, untested objectives for reducing diagnosis specific Medicare admissions, developed unilaterally without examination or comment by affected parties. So far, we have seen the targets for reducing Medicare hospital admissions and procedures, but we have not seen a clear and detailed explanation or substantiation of these caritería as being appropriate, for the various local review areas.

The key element in effective utilization review should be whether the procedure or admission is medically necessary, not whether a certain reduction in services will achieve a certain level of cost savings. Such an approach will result in the denial of appropriate care. It is essential to the success of this program that PROs have more flexibility in establishing appropriate standards and carrying out their activities, rather than being tied to quotas whose source, purpose and validity are questionable.

Hospitals and physicians desire to deliver quality, cost effective medicine. The Medicare hospital prospecitive payment system enacted last year has given strong incentives for providing appropriate medical services and in the appropriate setting.

It is clear from recent hospital admission and expenditure figures that the prospective payment system is working. However, an enduring concern is the provision of quality care as well. The use of cost reduction targets turns attention away from this critical element in utilization and quality review. Effective utilization review benefits providers, beneficiaries and payers, and it is in the best interest of all to make sure the PRO program is effective and not viewed as arbitrary, rigid and unworkable by the provider community.

We applauded the efforts of Senator Durenberger in attempting to formulate a more effective peer review program. We fear, however, that the Chairman's well intentioned efforts have been distorted and thwarted by the regulations implementing his legislation. We urge the Department to reconsider its objectives for PROs and to work with providers to help establish valid standards for reviewing medical necessity and appropriateness in the provision of care to Medicare beneficiaries. We also ask for continued Congressional oversight to guarantee the establishment of a PRO program that holds the delivery of medically necessary and quality health care its primary goal, rather than cost justification of its program.

STATEMENT OF THE KANSAS HOSPITAL ASSOCIATION

FOR THE

SUBCOMMITTEE ON HEALTH OF THE SENATE FINANCE COMMITTEE
OF THE UNITED STATES SENATE

ON THE ISSUE OF THE IMPLEMENTATION
OF THE PEER REVIEW ORGANIZATION PROGRAM

Hearing Date: July 31, 1984

Dear Senator Durenberger and Members of the Subcommittee:

The Kansas Hospital Association (KHA), on behalf of its 180 member hospitals and health care related institutions, appreciates this opportunity to comment on the implementation of the Peer Review Organization (PRO) program.

KHA supports the development of an effective utilization review program which focuses on the quality and the medical appropriateness of the care furnished to Medicare beneficiaries. However, we are concerned about the PRO program as it is currently being implemented by the Health Care Financing Administration (HCFA) in response to the Peer Review Improvement Act of 1982. KHA believes the congressional intent in passing this legislation to authorize replacement of Professional Standard Review Organizations (PSROs) was to streamline and simplify the process for the government as well as the medical community. This means the new PRO program should be cost efficient, beneficial and effective for both the government and hospitals. Our specific concerns include: the establishment of PRO objectives; the denial rate and its implications for hospitals' waiver of liability; the lack of opportunity for public comment and participation in the development of PRO policies and procedures; the centralization of the PRO review process which has resulted in a shifting of costs from the PRO to the hospital; data confidentiality; and the physician's attestation statement. Generally, KHA

is recommending there be complete and open communication and the development of a truly working relationship rather than an adversarial relationship among HCFA, the PROs and the providers. In addition, KHA believes that HCFA should:

- grant the PROs more flexibility in establishing their review procedures and objectives;
- provide for considerably more confidentiality of data;
- recognize the additional costs being borne by hospitals as a result of the new review process; and
- establish incentives to recognize and reward those hospitals that are doing an effective job of utilization management.

KHA appreciates the continued interest the Subcommittee has shown in the PRO implementation and its assistance in the enactment of certain amendments to the Deficit-Reduction Act of 1984. KHA strongly believes that the PRO governing board should be a forum where medical review policies can be addressed by a cross section of community interests which include providers. By permitting hospital representation, Congress has recognized the PRO program should not be an adversarial one, but rather one where federal government, physicians and the hospital industry can become working and willing partners in building a new review program -- a program which is administratively rational and cost effective, while at the same time tailored to address the incentives created by Medicare's new Prospective Payment System (PPS). The ability of these parties to work together during this

critical period of transition will set the tone for the future and may well determine the success or failure of not only the PRO program, but the Medicare program in general.

Specific PRO Implementation Issues:

I. PRO Objectives

We will not go into the details of the specific PRO review activities. These have already been outlined in the background paper prepared for the use of the members of the Subcommittee and in the comments of the American Hospital Association and the American Medical Peer Review Association. However, we do want to note our deep concern with the prescriptive approach to the review that is being taken by HCFA. This type of review burdens good hospital and physician performers with unnecessary monitoring and additional costs. And does not provide the PRO physician advisors and staff with the flexibility to concentrate on activities in identified problem areas or with specific providers.

Many of the PRO review plan categories mandated by HCFA overlap with the objectives HCFA is negotiating in the PRO contracts. Furthermore, it does not appear reasonable to expect a single uniform approach to effectively address the different quality of care and utilization problems throughout the nation. This variance in medical care is demonstrated by a study recently released by Project HOPE. The study specifically identified wide variations in use rates for various medical procedures. Not surprisingly, the study goes on to state that the wide variations are primarily the result of "practice style". "Practice style" or how and in what setting a

physician is likely to treat a particular medical problem can be the result of many factors including the doctor's age, the practices in vogue when he or she attended medical school, the particular medical school he or she attended, the community in which the physician lives, the attitudes towards defensive medicine and the practice patterns of other doctors in that community. The study found these factors result in individual practice styles which combine to create recognizable "medical signatures" for different communities. Since physicians direct about 70 percent of this country's health care expenditures, practice styles and medical signatures are important variables in any utilization or cost equation. However, researchers indicate it is impossible to know whether a particular procedure's low use rate in one community or high use in another is more appropriate. To make such determinations, controlled studies producing hard data are needed.

To effectively address the necessary changes in practice style, several steps need to be taken. First of all, the procedure use rates, hospital admission rates and outcomes of different areas must be monitored. This information should then be gathered, analyzed and eventually disseminated to hospitals and physicians to create a greater awareness of cost-effective practice styles. Physician education is the key in this effort.

Physicians and hospitals do not want to overuse, misuse or unnecessarily drive up health care costs. Many of the practice styles of today are due largely to uncertainty and the practice of conservative or defensive medicine. The medical literature today contains little hard data on the outcomes and consequences of most procedures. Once these are known, physicians and hospitals will alter their behavior appropriately in

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response to the new information. This type of education and research, which in the long run could most effectively benefit the Medicare program and the health care of the United States, appears to be lost in the new Peer Review Organization program. The rigidity of the procedures, the setting of absolute numerical objectives often without regard to medical necessity, and the lack of PRO funding to (1) provide on-sight review and education to hospitals and physicians; and (2) to refine and work on definitions and measurements of quality and cost-effective medical practice insures that these types of questions and positive activities will not be undertaken by PROs.

While the PRO legislation specifically called for negotiated objectives against which the PRO's performance would be judged and measured, HCFA's use of goals related to "the elimination of avoidable deaths" and "reductions in admissions" are beginning to cause serious concerns not only in hospitals and with physicians, but also with the public. While HCFA argues that the numerical "goals" are based on information obtained in each state, and therefore representative of the needs of those communities, generally these objectives have been established using national norms and comparisons which may not be appropriate. Furthermore, HCFA seems to be set on requiring a set number of admissions to be reduced rather than relating these objectives to a reduction in the rate of Medicare admissions per thousand. In addition to this, HCFA is not allowing the PRO to tailor their objectives to meet specific local needs once the PRO has had a chance to thoroughly evaluate and analyze the actual situations with respect to each of their objectives. Right now these objectives are based on data which indicates there "appears" to be a problem rather than situations where it is actually known by the PRO that a problem exists. This could

result in situations where the PRO is trying to address and being held accountable for objectives in an area that eventually turns out to be a non-problem area.

The Kansas Hospital Association therefore recommends that HCFA grant the PROs the flexibility to re-negotiate and alter not only their objectives, but also their review plans, to meet the needs of the community(s) they serve; to provide education and research to assist in evaluation and changing of "practice styles," if change is needed; to establish objectives geared towards reducing the Medicare admissions on a rate per thousand basis rather than on a set number of admissions for each objective; and to specify that any reductions in rates are to be solely from the elimination of medically unnecessary or inappropriate care.

II. Denial Rates/Waiver of Liability

Many of the formulas established as part of HCFA's utilization review program fail to distinguish between hospitals and physicians with good review records and hospitals and physicians with utilization problems. Regardless of a hospital's review experience, the hospital can expect to have a minimum of 25 to 35 percent of their Medicare cases reviewed. In addition, the denial rate is set extremely low at 2.5 percent. This rate is used by HCFA for determining whether a hospital will be subject to 100 percent review of its cases and for determining whether a hospital will have a favorable waiver of liability presumption. If a hospital does not have a favorable presumption, it will be subject to retroactive payment denials. We recognize that a 2.5 percent denial rate was used prior to the

PRO program. However, HCFA's methodology for calculating the denial rate has changed significantly. Rather than dividing the number of Medicare admissions denied in the PRO's review by the total number of Medicare admissions to the hospital, HCFA is now dividing the number of Medicare admissions denied in the PRO's review by the Medicare admissions the PRO reviewed for the quarter. In Kansas, this has resulted in only five hospitals falling under the new criteria or the 2.5 percent denial rate. In other words, virtually all Kansas hospitals are now subject to 100 percent review of their medical records. This also means that these hospitals no longer have a favorable waiver of liability presumption. In Kansas, most of these hospitals on a 100 percent review are small, rural hospitals, and are now being required by the PRO to copy and mail their medical records to the PRO for review. This creates additional administrative burdens for not only the hospitals but for the PRO. It also creates considerably more additional costs for these hospitals to comply with the PRO program's requirements. And finally, it is also these small, rural hospitals that are at an extreme financial risk for potential cases that may be denied as a result of the PRO review, since their waiver of liability has been revoked.

The Kansas Hospital Association does not believe a 100 percent review is beneficial or cost effective for either the Medicare program or the hospital. Such review should only be undertaken in hospitals where there has been a demonstrated problem. We suggest HCFA establish positive incentives for hospitals and physicians with good review records by allowing for flexible review procedures and the delegation of review functions where the hospital has demonstrated the effectiveness of its in-house utilization management program. KHA believes it was Congress'

intent to provide PROs with such flexibility and to reward provider behavior rather than constantly penalizing providers. At the very least, PROs should be able to eliminate HCFA-required review activities when the PRO can demonstrate that the review process is not uncovering patterns of inappropriate hospital behavior.

It is time to reward those who are good performers and target utilization review energies where the payoff is the greatest. HCFA appears to be deliberately eliminating any possible waiver of liability for the hospital, and basing this loss of waiver on a process that is a "hindsight," and sometimes subjective, review. HCFA should be requested to establish more realistic and reasonable denial rates and instructed to preserve rather than eliminate a hospital's favorable waiver of liability presumption unless it can be shown that the hospital has been extremely negligent or fraudulent in its utilization management or medical record documentation.

III. Lack of Provider/Public Participation

KHA is upset with HCFA's delay in publishing the regulations governing implementation of the PRO program and the interim implementation of PRO policies and procedures without an opportunity for public comment. Currently the PRO program is being implemented and PRO contracts are being negotiated without any final regulations governing the conduct review, the reconsideration and appeal process, the sanction procedure or the acquisition and disclosure of data by PROs. While Notices of Proposed Rule Makings (NPRMs) have now been issued governing each of these areas, the latter two were not issued until April, almost 20 months after the passage

of the Peer Review Improvement Act and the first two NPRMs were just issued July 17. The provisions of the NPRMs have been implemented in the interim by HCFA via PRO transmittals or letters and other non-public PRO communication channels. Thus, major changes and revisions to the PRO program are often being imposed on hospitals without notice and have still been incorporated in HCFA's Request For Proposals (RFPs), and the PRO-HCFA contracts now being signed.

When regulations were finally issued, the public comment period was limited to 30 days. This provides little time for dissemination of the proposed rules to Kansas hospitals and the preparation of informed and constructive comments. Furthermore, since the PRO contracts and related technical proposals are currently being negotiated between the PROs and HCFA, and since these include the provisions of the regulations or proposed rules, it appears HCFA does not plan to sincerely evaluate and consider any public comments.

In addition to the lack of adequate opportunities to comment, hospitals are being given little opportunity for a meaningful negotiation of their PRO-hospital agreements. PROs have been instructed in their negotiations with HCFA (1) basically where to perform on-sight versus off-sight review; (2) not to reimburse any additional costs incurred by hospitals as a result of having to copy and mail records or undergo a 100 percent review; (3) the procedures (or lack of them) to use in preserving the confidentiality of data; and (4) the specific review procedures the PROs are to use. PROs are also being instructed to obtain agreements with hospitals immediately, while at the same time HCFA is making these agreements subject to the

yet-to-be-released HCFA guidelines. Lastly, if hospitals do not sign the PRO agreement, even though they may have some valid and legitimate concerns with the agreement, they will lose their Medicare participation.

KHA is committed to working with HCFA and our area PRO to establish and maintain effective working relationships between hospitals, physicians and PROs. We feel fortunate in Kansas that our PRO has attempted to keep us abreast of the developments within their technical proposal, their HCFA-PRO contract, and the dictates from HCFA. The Kansas Foundation for Medical Care (KFMC), our designated PRO, has provided an opportunity for Kansas hospitals to comment on the review requirements in its review plan and the hospital agreement. However, KFMC is severely restrained in the latitude they can use in responding to the concerns Kansas hospitals have voiced. We will continue to work with KFMC, and hopefully with HCFA, to develop an effective utilization program. However, this cannot be done if serious consideration is not given to hospitals' comments and to developing an attitude of working with the provider community (instead of an adversarial one). The health care industry is so complex that the federal government cannot afford to eliminate or ignore constructive comments from the provider community.

IV. Centralized, Non-Delegated Review

The PRO program being implemented currently by HCFA is solely a non-delegated, prescriptive review. Currently the program provides few rewards for those hospitals having effective in-house utilization management and peer review programs. While the Peer Review Improvement Act explicitly

allowed a PRO to establish subcontracts with hospitals that have demonstrated the ability to perform, HCFA has totally rejected the concept of hospital-based review. While we understand their concern that the review process has a significant bearing on payment, we also realize, if implemented improperly, it can have a significant negative bearing on hospitals' cost. HCFA's policy has two impacts that the Kansas Hospital Association is seriously concerned about:

1. Most of the review in Kansas will be conducted outside of the hospital at the PRO office. This will mean Kansas hospitals, primarily small and rural hospitals, will be photocopying large numbers of medical records. The HCFA-proposed regulations issued July 17 prohibit the PRO from paying hospitals for the costs incurred in copying and shipping medical records. And HCFA has explicitly excluded funds for this purpose from the PRO contracts. HCFA states these costs were covered under the cost reimbursement system and, consequently, reflected in the DRG prices. However, as we stated earlier, the volume of review and thus the records demanded has increased sharply under the new PRO procedures. Therefore, any costs borne in the past are far less than those currently being borne by Kansas hospitals.

   Once again, HCFA has managed to shift costs from the Medicare program to non-Medicare patients. Even those hospitals, where on-sight review will be performed, will be bearing additional costs not recognized by HCFA. In Kansas, these hospitals will be subject to a mandatory 100 percent review regardless of performance. This will

mean not only constantly making space available for the PRO review staff, but constantly making available medical record personnel and medical staff available to assist the PRO in their review.

Once again, because the volume of review has significantly increased, these costs were not included in the historical costs of hospitals. It is interesting to note that in the July 3 proposed rules governing Medicare's Prospective Payment System for fiscal year 1985 HCFA has managed to decrease the federal and hospital-specific rates for "improved inefficiencies in hospitals' medical record documentation and coding." However, HCFA has not likewise seen fit to increase those PPS rates for the additional costs hospitals are incurring because of the new PRO review procedures and the importance now being placed upon the medical record. Hospitals are having to increase the medical records staffing in order to comply with the increased importance and intensity being placed on the medical record.

Again, the PRO program as it is being implemented by HCFA does not provide incentives for good performers. A program encouraging the development of strong hospital-based review systems would better serve Medicare and its beneficiaries than one that removes the incentives to make utilization review a central part of hospitals' internal management structures. A competitively based program should reward efficient and good performers rather than establishing across the board penalties.

V. Data Confidentiality

In general, while the intent of the Peer Review Improvement Act was to protect against unauthorized access to confidential data and to specifically exclude PROs from the provisions of the Freedom of Information Act, the NPRMs issued by HCFA in April governing the acquisition, protection and disclosure of information by PROs emphasize circumstances when the PRO can release data and the obligation of the PRO to provide confidential and other information to the public. Specifically, the NPRM defined "confidential information" to include only information that explicitly or implicitly identifies an individual patient, practitioner or reviewer. The omission of hospitals from this definition renders all institution-specific information "non-confidential."

Section 1160(a) of the Peer Review Improvement Act requires the Secretary to promulgate regulations that "assure adequate protection of the rights and interests of patients, practitioners and providers." (Emphasis added.) Section 1160(b) requires the Secretary to "establish procedures and safeguards to protect individual patients, practitioners and providers from unnecessary disclosures." (Emphasis added.) While the April NPRM described potential results of public disclosure of practitioner-specific information, these examples of potential misrepresentation of data could equally apply to hospitals or the health care industry as a whole. For example, statistics demonstrating a high (but justified) ratio of patient deaths for a given hospital could be misleading to the public, particularly if the hospital's case-mix information is not supplied and fully explained as well. Such a misrepresentation of data is well demonstrated by a recent article printed in the Wichita Eagle Beacon, July 29, 1984. This article

which came from the New York Times News Service stated, "The Kansas contract said that 'data from October, 1983 to February, 1984 revealed a 7.8 percent rate of substandard hospital care' that forced patients to return to the hospitals for more treatment." This statement infers that 7.8 percent of the hospital care rendered in Kansas is substandard. What KFMC's technical proposal actually said was that in establishing a Kansas objective for the HCFA-mandated quality objective of "reducing unnecessary readmissions resulting from substandard care provided during the prior admission," the verification data used by the PRO to set this objective showed that "between October, 1983 through February, 1984, 64 readmissions within seven days from 10 Kansas hospitals were reviewed by KFMC. Of these readmissions, five (7.8 percent) were related to substandard care provided during the prior admission." (Emphasis added.) Five cases is a far cry from the 7.8 percent of all admissions that is being inferred from the article printed in the Wichita Eagle Beacon!

This shows the importance of maintaining the confidentiality of the data obtained by the PRO and the potential for misuse and misrepresentation when it is released to parties unfamiliar or uneducated in the medical arena. In addition to permitting the release of this type of information, the April NPRM only mandated that 15 calendar days notice be given to a provider before a PRO discloses information to a requesting party. Fifteen calendar days does not allow a provider adequate time to receive and comment upon the information to be disclosed.

While the April NPRM limited redisclosure of peer review information by persons or organizations receiving such information, once agencies other than the PRO have obtained confidential information the extent to which the

PRO can realistically guarantee the information's protection is seriously open to question. Congress itself acknowledged the problem of redisclosing this data by imposing the same penalties on the receiving agency for improper disclosure of information as would be imposed on the PRO. Although the April NPRM explicitly limits redisclosure, these provisions do not guarantee the protection of any information held by a public agency, including HCFA, from discovery under the Freedom of Information Act and other state laws. Therefore, it is essential that regulations specifically limit agencies and organizations to which the information would be available and specify what information can be provided. Under no circumstances should access to provider-specific or patient-specific information be provided, other than on-sight at the PRO, to any agency.

These are just a few of the concerns the Kansas Hospital Association has with respect to the lack of provisions to protect the confidentiality of data supplied to the PRO. Our comments to HCFA's April NPRM detail our concerns and suggestions. A copy of these comments has previously been given to the Senate Finance Committee staff.

VI. **Physician Attestation**

The January 3 regulation governing the Prospective Payment System for fiscal year 1984 required the attending physician to sign a statement at the beginning of the patient's chart certifying the accuracy of the description of the principle and the secondary diagnosis and the major procedures performed. The statement also included a notice stating anyone who misrepresents, falsifies or conceals essential information would be subject to fine, imprisonment or civil penalty.

With the HCFA-proposed regulations published July 3, some of our concerns have been eased. The proposed regulations modify the previous policy by requiring the physician to sign a statement specifically indicating that he or she is only certifying the narrative description of the principle and secondary diagnosis and the major procedures performed. We believe this statement now clarifies a number of concerns physicians had about potentially being held responsible for the actual coding of these diagnoses and procedures. However, HCFA did add a new requirement that the statement be located on the discharge summary sheet in the patient's record.

The Kansas Hospital Association believes it is too prescriptive to mandate that the attestation be on the discharge summary. Kansas hospitals have developed their own methods and procedures of documentation of the final diagnoses and procedures performed, unique to the individual hospital's and medical staff's needs and standard operating practices. Such practices were well established years prior to the 1984 required attestation statement.

Since the attestation statement's implementation, each hospital has developed its own method of compliance, taking into account what is most efficient for its medical staff and individual hospital circumstances. As such, a variety of formats exist throughout Kansas hospitals. These formats include the use of a separately developed DRG validation form, the medical record face sheet, the discharge summary or an equivalent means. The majority of Kansas hospitals appear to be using the face sheet or separate validation document rather than the discharge summary.

Requiring the use of the discharge summary as the sole acceptable document for the attestation will mean a considerable disruption of existing methods in many Kansas hospitals and a re-education of the medical staffs. Kansas hospitals have been using formats other than a discharge summary in order to ease any cash flow delays caused by a delay in completing the discharge summary. Most medical staff bylaws allow at least 30 days for the attending physician to complete the discharge summary. However, the medical record face sheet is often completed and signed by the physician shortly after a patient's discharge. The primary purpose of the medical record is to facilitate the patient's care and to serve as a communication tool among the health care professionals. Physicians and hospitals should not be placed in the position of being required to reconstruct the medical record for the secondary purpose of substantiating payment to the detriment of its primary purpose. The Kansas Hospital Association is adamantly opposed to the requirement of using solely the discharge summary for the attestation statement.

In general, we also believe the attestation statement is unnecessary. By virtue of the signature on the face sheet, discharge summary or other documents in the medical record where diagnoses and procedures appear in writing, the physician is already attesting to his narrative descriptions of the principle and secondary diagnoses and major procedures. Consequently, a written statement to that fact is redundant.

Furthermore, the signed acknowledgement by the physician certifying that he or she is aware of the penalties for misrepresentation, falsification or concealment also appears unnecessary. The narrative description of the diagnoses and procedures follow a procedure established since modern

medical record documentation began. The fact that those descriptions are now used to determine payment does not change the essence of an acceptable narrative description. Physicians are well aware the medical record and its contents constitute a legal document and thus consequences exist for any fraudulent or other illegal activities. Rather than burden all hospitals and physicians with obtaining a document to that effect, it would seem more prudent for the government to issue a one-time notice and then to prosecute the few physicians who may undertake such fraudulent acts, in the same manner that the government has prosecuted offending physicians for fraudulent activities in the past.

Again, KHA expresses our appreciation for the opportunity to present our views and recommendations concerning the implementation of the PRO program. The Kansas Hospital Association and its member hospitals want to be an active participant and partner in establishing an effective, innovative utilization review process for Medicare, rather than being merely a spectator or a non-entity in the process. We wish to provide constructive comments on the proposed policies and procedures, and work with HCFA and our area PRO to obtain an effective, cost-efficient program for not only Medicare, but Kansas hospitals and physicians as well.

We thank you for your continued interest in the implementation of the PRO program.

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